THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

FEBRUARY, 1950

Congratulations!

to Masonic Home, Zenith, Wash.,

on its Compact,

Highly Efficient,

Laundry Department

All linens, blankets, curtains, etc., are laundered in this compact laundry consisting of 2-Roll STREAMLINE Flatwork Ironer, ZONE-AIR Drying Tumbler, Solid Curb Extractor, 25-lb. and 50-lb. CASCADE End-Loading Washers.

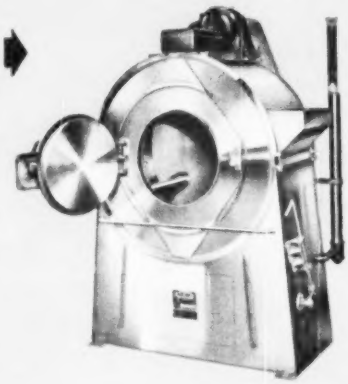
PROBLEM: This Masonic Home, which cares for 160 elderly persons, questioned whether its clean linen problem was being handled most efficiently and economically.

SOLUTION: Our Laundry Advisor was requested to make a thorough study and submit all findings. His report listed actual benefits to be obtained by installation of a small, efficiently equipped laundry department. Masonic Home then decided to install the laundry according to specifications supplied by the Laundry Advisor.

RESULTS: The Superintendent reports savings of $833 during first 3 months of operation. Other benefits include "better quality work", "faster return of linens to service" and "smaller linen inventory."

Hospitals, large or small, are invited to discuss their laundry problems with our Laundry Advisor. No obligation. WRITE TODAY.

CASCADE End-Loading Washer. Masonic Home uses two of these late-type washers, one 50-lb., one 25-lb. dry wt. capacity. Famous CASCADE *through-and-through washing action* gently, yet thoroughly, washes linens sterile-clean with amazing economy. Washers feature extremely simple operation; are sturdily constructed of Monel metal for dependable service.



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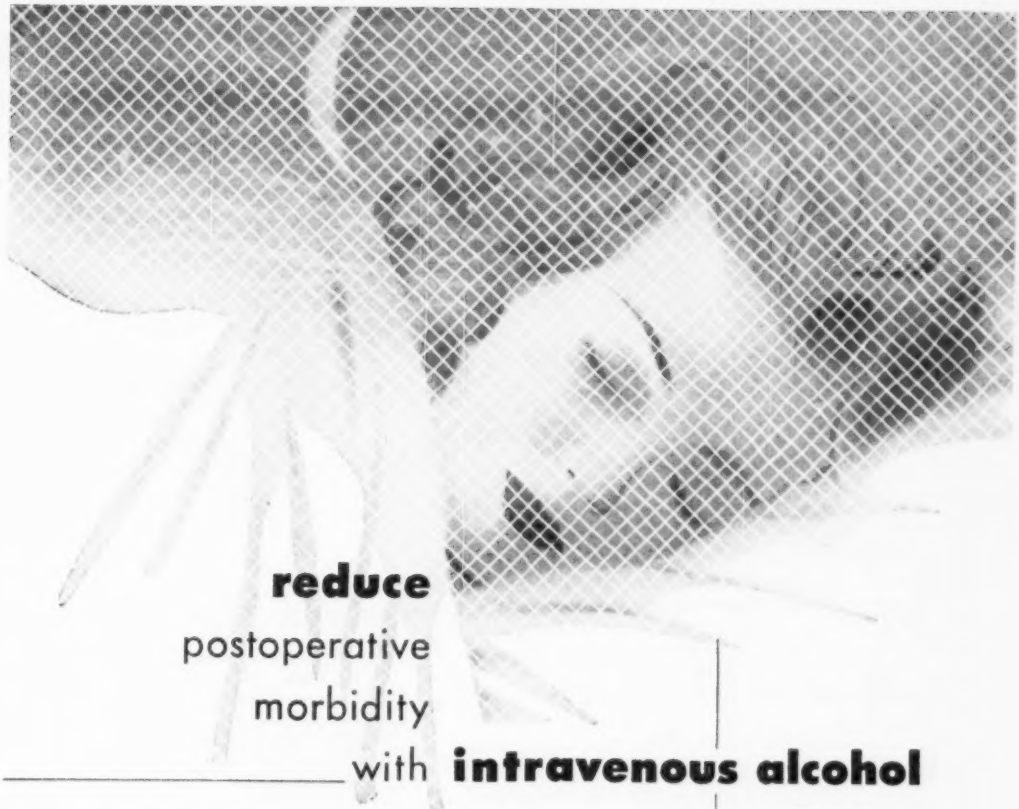

reduce postoperative morbidity with intravenous alcohol

Quiet, restful sleep following surgery may be easily induced by the use of intravenous alcohol as a sedative and analgesic.[1] Cough, gas pains, urinary retention, vomiting, and fever are materially reduced when alcohol is used to decrease or eliminate the use of morphine.[2,3]

Since alcohol is a food as well as a drug, it is almost completely metabolized. In addition to the sedative and analgesic qualities, one liter of 5% Alcohol, 5% Dextrose solution furnishes 475 calories. When properly administered, undesirable side effects are rarely encountered.

BIBLIOGRAPHY

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2. STRICKLER, J. H., RICE, CARL O.: The Role of Narcotics in Postoperative Morbidity, Minn. Medicine 31:5, 540 (May) 1948
3. RICE, C. O., STRICKLER, J. H., *et al:* Parenteral Nutrition, Journal-Lancet, 68:91 (March) 1948

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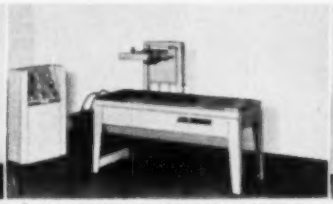
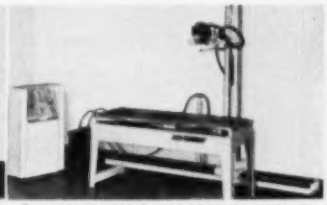
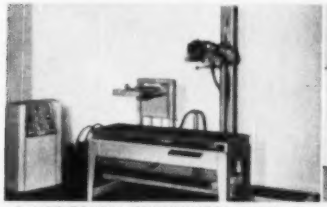
1. **HORIZONTAL BUCKY TABLE.** The horizontal table equipped for radiography includes a Potter-Bucky diaphragm mounted directly under the table top. For intermittent use at low milliamperages, with a mobile or portable-mobile unit, it makes an ideal unit for straight radiographic work.



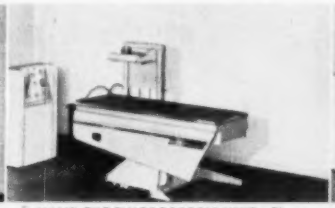
2. **HORIZONTAL FLUOROSCOPIC UNIT.** The basic horizontal table can be transformed into a straight fluoroscopic table by the mere addition of the fluoroscopic carriage and screen unit plus a tube mounted under the table. The 100-ma generator and Maxicon control complete the unit.



3. **HORIZONTAL RADIOGRAPHIC UNIT.** The horizontal Bucky table augmented by a stationary anode tube mounted on a tube stand and floor rail provides every facility for horizontal radiography. The 100-ma generator and Maxicon control provide for technics up to 100-ma at 90 kvp.

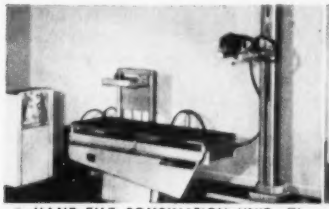


4. **HORIZONTAL COMBINATION UNIT.** For those who prefer a horizontal table to serve for both radiography and fluoroscopy this Maxicon combination unit is functionally unlimited. One tube serves as the x-ray source both over and under the table.



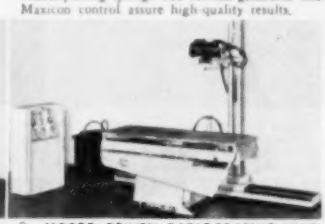
5. **HAND-TILT FLUOROSCOPIC UNIT.** Fluoroscopy from Trendelenburg to vertical is easily accomplished with this unit in the Maxicon series. Equipped with the spot-film device, an even greater range of service can be yours. Panels in the table-front opening shield you from scattered-radiation.

6. **HAND-TILT RADIOGRAPHIC UNIT.** The angulating table provides every convenience and facility to make radiography in angular positions an exact procedure. Manual raising of the table is effortless, supplemented by the power of a counterposing spring. The 100-ma generator and Maxicon control assure high-quality results.

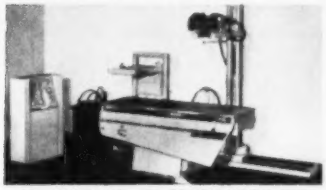


7. **HAND-TILT COMBINATION UNIT.** The separate features of the radiographic and fluoroscopic models are embodied in this combination unit. It can quickly and conveniently be adapted to every type of x-ray examination. Its outstanding flexibility permits the use of one tube for radiography and fluoroscopy.

8. **MOTOR-DRIVEN FLUOROSCOPIC UNIT.** Foot-pedal angulation of the table affords complete fluoroscopic convenience. The operator's hands remain free, for palpation of the patient and manipulation of screen and shutter controls. Scattered-radiation protection and an automatic field-limiting device are important features.



9. **MOTOR-DRIVEN RADIOGRAPHIC UNIT.** The variable-speed angulation of the Maxicon table is controlled by two conveniently located foot pedals. All degrees of tilt from Trendelenburg to vertical are self-retaining for radiography in any position. A complete range of power and capacity are provided by the rotating-anode tube.



10. **MOTOR-DRIVEN COMBINATION UNIT.** The composite of x-ray facilities in this combination unit equips you for complete radiographic and fluoroscopic service. The separate rotating-anode tube units increase the capacity of a busy department. The 200-ma generator and Maxicon control contribute the means for obtaining high-quality results accurately and routinely.

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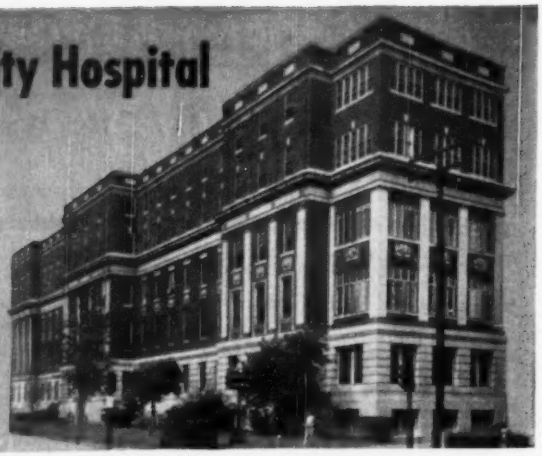
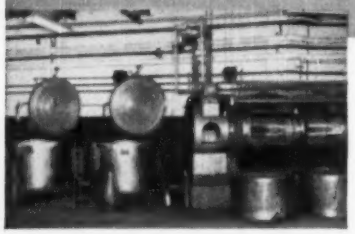
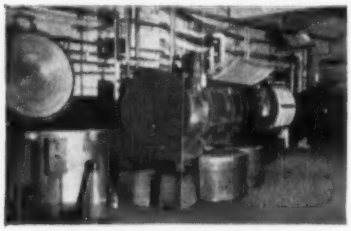
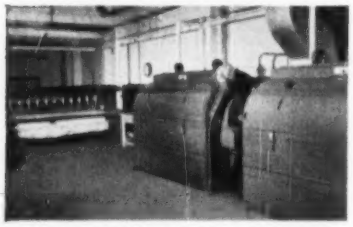




Two 50" unloading extractors (left) and central supply system (see controller stand at washer) provide fast, economical washing.



Three automatic 44 x 84 Shell-less Washers, elevated for faster dumpout, handle 350-pound loads on fast schedule.



Two 42 x 90 "Balanced Suction" tumblers and one 8-roll Chest Type flatwork ironer round out Temple's modernized laundry.

. . . 29% more linen is done
. . . in ½ the time
. . . with ½ the labor cost
. . . FOR ONLY 3¢ PER POUND

Including Direct Labor, Supplies, Water, Steam to Heat Water, and Electricity

TWO YEARS AGO, when the Temple University Medical School and Hospital, in Philadelphia, was considering general expansion, the need for improved laundry service was even then critical in the existing hospital. A survey made by U. S. Hoffman laundry engineers revealed a high turnover in laundry personnel – a six-day work week averaging 11 hours a day – generally inadequate facilities for processing Temple's 27,000 pound per week volume.

Modernization of the laundry, therefore, was made an integral part of the expansion program which Temple undertook last year.

With its new capacity of 600 beds, weekly laundry volume now stands at 35,000 pounds, including the work of student nurses and interns. Hoffman "Shell-less" washers and unloading extractors, along with Hoffman tumblers and flatwork ironer, are processing this 29% heavier volume for only 3c per pound. Hoffman equipment is credited with helping the Temple laundry staff to do "more work in eight hours than in sixteen in the old plant. Soap and other supplies have been cut almost in half – less linen discarded."

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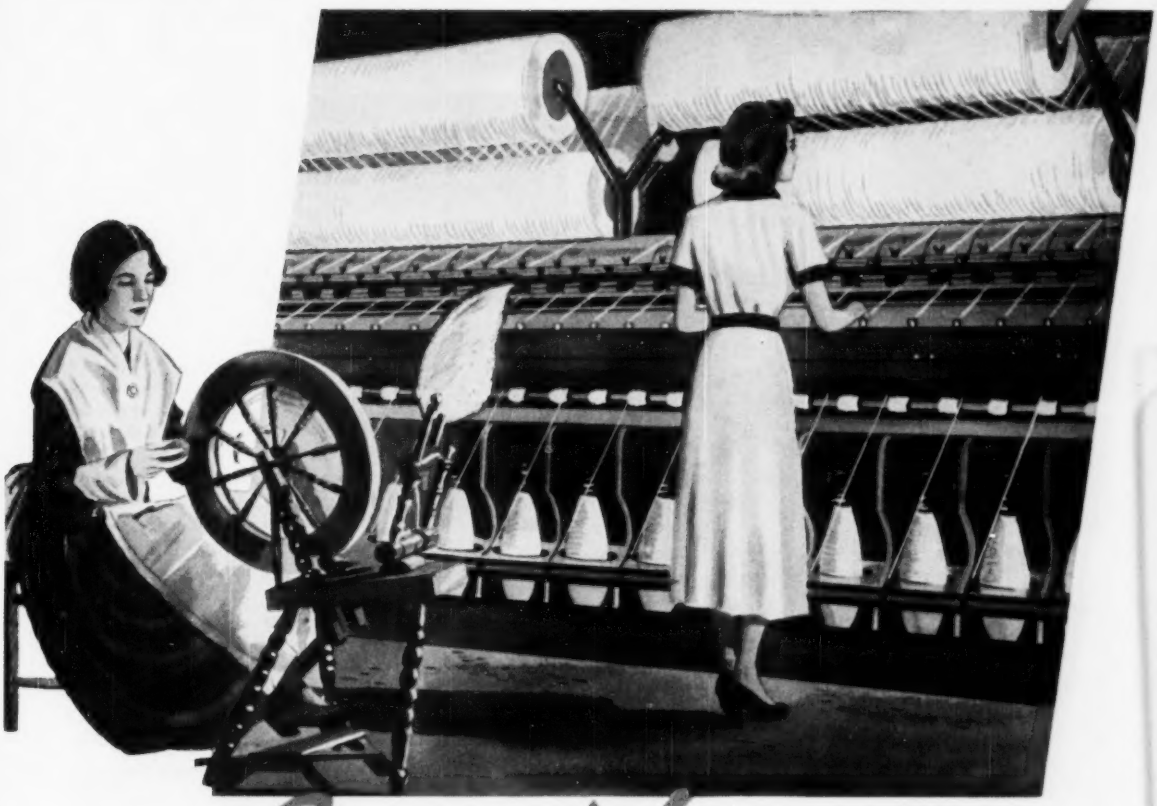

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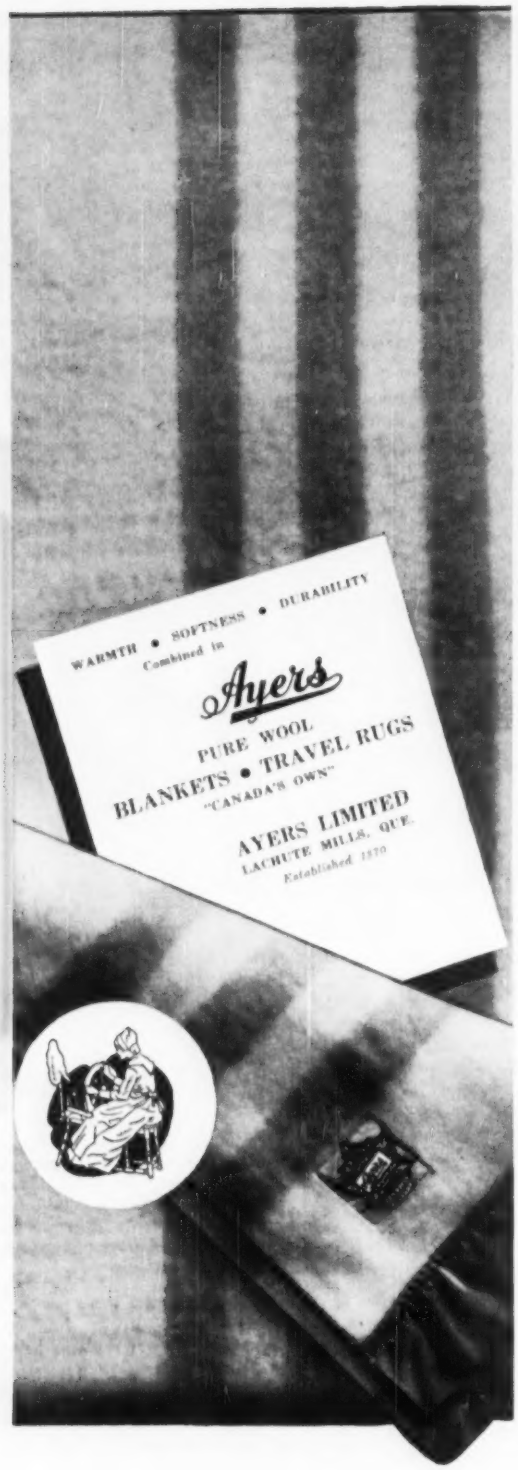

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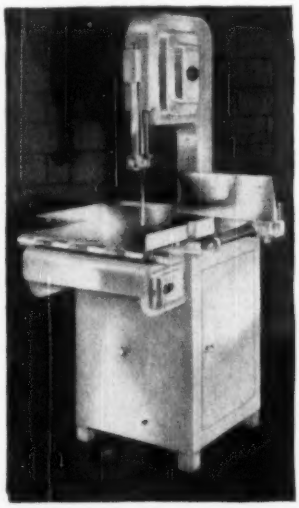
Some twenty-four years ago A. "Brock" Shore joined the Production Department of the Palmolive Company. Having a good knowl- of soap making he became eager to be helpful to the rapidly increasing industrial clientele, with the result that in 1935 he was made Industrial Representative for Western Ontario. A few years later he was transferred to the Toronto territory where the Company say he has done an outstanding job.

Recently Mr. Shore was appointed Industrial District Manager for the Province of Ontario. He will be at Head Office, Colgate-Palmolive-Peet Company Limited, 64 Natalie Street, Toronto.

* * * *

Hobart Power Saw Is Introduced

With new efficiency features and refinements in design, the new Hobart Model 5213 Power Meat Saw is now being introduced to hospitals. The manufacturer points out the smooth flowing surfaces and remarkable accessibility which make this saw easy to keep clean. All parts which require cleaning are quickly detachable without tools.



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(Continued on page 16)

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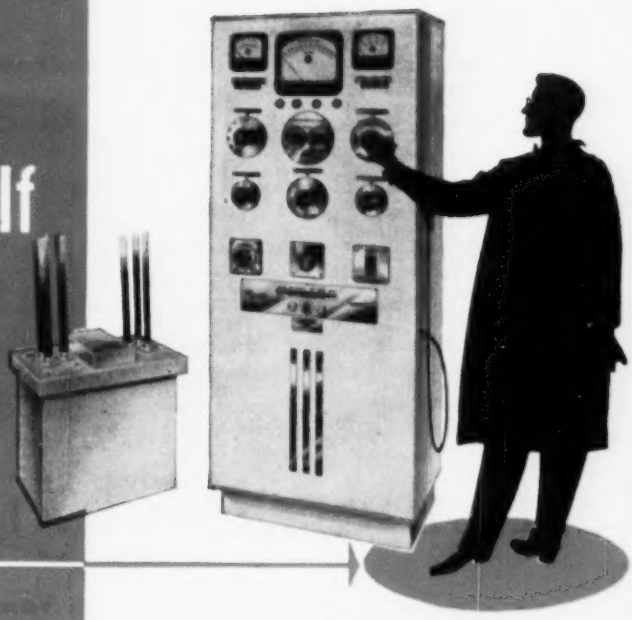

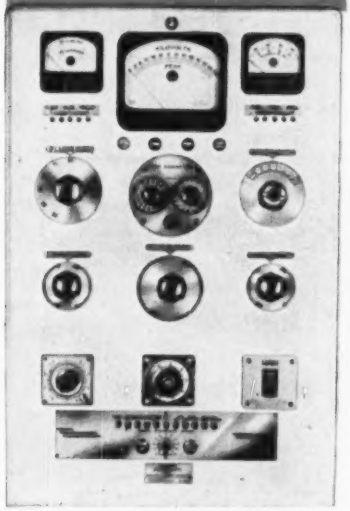

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- Most cases of mastitis can be traced to nipple fissures or sore nipples which DeLee estimates affect more than half of all lactating women.
- Many breast complications can be avoided when the use of PLASTISHIELDS, begun in the hospital immediately after parturition, is continued at home.
- PLASTISHIELDS are clean, simple to use and comfortably worn.
- They are easily sterilized and prevent soreness, cracking and fissuring of nipples.
- You are invited to write for further information on the PLASTISHIELD Technic of Aseptic Breast Care.

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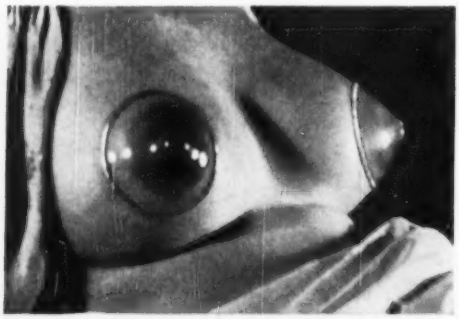

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Plastishield, inc.

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A non-capillary silk of exceptional tensile strength, outstanding for many years as a specialty suture in combination with D&G Atraumatic® needles, Anacap Black Braided Silk is now available on spools, unsterilized, in lengths of 25 and 100 yards and in range of sizes from 6-0 to 5.

Packed in a convenient plastic box, Anacap Silk is well protected from dust and dirt and may be readily sterilized by boiling or autoclaving.

Non-capillary under all conditions to which sutures are exposed, D&G Anacap Silk is of such high tensile strength that it may be used in finest sizes without danger of breaking. It is free from stiffening lacquers or traumatizing substances.

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Special Products for every type of cleaning

DYE & CHEMICAL CO. OF CANADA LTD.

KINGSTON, ONTARIO — Established 1895

Across the Desk

(Continued from page 12)

Gumpert President Dies

Daniel W. Janover, President of S. Gumpert Company, Inc., New York, died on Tuesday, January 17 at his home in New York City, after a brief illness. He was 61 years old. He also was President of S. Gumpert Co. of Canada, Ltd.

Born in New York City, Mr. Janover was graduated from New York Law School and admitted to the Bar in 1911. He became associated with his father-in-law, Sally Gumpert, and brother-in-law, Jack Gumpert, in S. Gumpert Company, Inc. in 1913, and following the death of Sally Gumpert in 1930 became President of the Company.

* * * *

Wood's New No. 12 Electric Floor Polisher

The new G. H. Wood No. 12 electric floor polisher is a light-weight floor machine for polishing and buffing. Attractively designed, it is made with a gleaming chrome plated finish.

Due to the position of the counter-rotating twin brushes this polisher gets right up to baseboards and into corners. It is sturdily built to give years of service and is ideal for use under any conditions where a convenient light-weight floor polisher is required.

Wood's No. 12 electric floor machine polishes waxed surfaces to a hard gleaming lustre that resists dirt and stays shiny longer. By means of clipped lamb's wool buffers it is possible to give the floor a soft, glowing "hand-rubbed" finish.

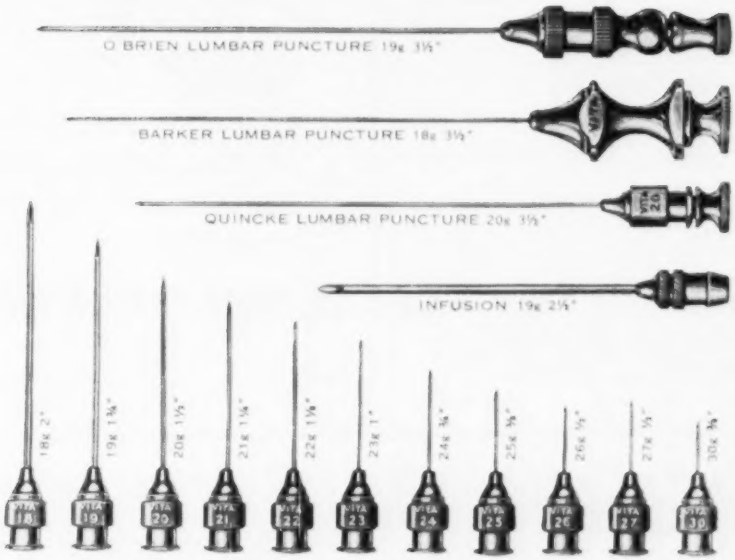
* * * *

Reduced Railway Rates to Trade Fair

The Canadian Passenger Association, in recognition of the importance of the Canadian International Trade Fair to the business and economic life of Canada, is co-operating with the Canadian Government by reducing railway fares for participants in the 1950 Fair, which will be held in Toronto from May 29 to June 9. It has announced that rail travel rates for the Trade Fair will be fare-and-a-half from any point of origin in Canada to the Trade Fair and return.

(Concluded on page 20)

A NAME TO REMEMBER!



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Nylon Shower Curtains

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Galatest FOR DETECTION OF SUGAR IN THE URINE

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SAME SIMPLE TECHNIQUE FOR BOTH

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COLOR REACTION IMMEDIATELY

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Write for descriptive literature

A carrying case containing one vial of Acetone Test (Denco) and one vial of Galatest is now available. This is very convenient for the medical bag or for the diabetic patient. The case also contains a medicine dropper and a Galatest color chart. This handy kit or refills of Acetone Test (Denco) and Galatest are obtainable at all prescription pharmacies and surgical supply houses.

THE DENVER CHEMICAL MANUFACTURING COMPANY
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You can't send an old hospital building to Arizona for a rest when it is run down, but there is a tonic known as Formica. Applied to unsightly walls, columns, and entrances, or used as baseboard or wainscot, bedside, overbed table tops, and dressers, one application restores the blush of beauty, youth, and health.

Be sure to specify Formica tops on all the new furniture you buy. They don't show wear, and they can't be spotted with food and drink, lighted cigarettes, mild acids or medicines.

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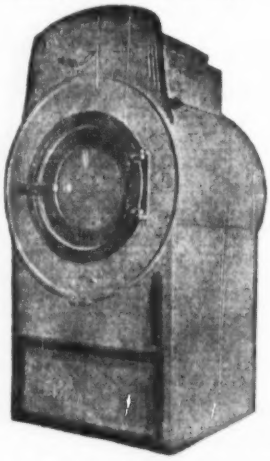

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Across the Desk

(Concluded from page 16)

"Inform Controls" in Treatment of Infant Formula

Smith and Underwood (Diack Controls) announce "Inform Controls", specifically for use in the terminal treatment of infant formula. Designed for use in the autoclave treatment of milk, the new Inform Control will exactly indicate when the desired exposure of 10 minutes at 230 F. has been obtained. An Inform Control suitable for use at a lower exposure of 25 minutes at 212 F. will be available early in 1950.

These exposure conditions conform to recommendations of the new "Manual on Infant Formula Rooms" just released by the American Hospital Association.

Inform Controls consist of a pellet suspended in a glass tube. The control is dropped into a test bottle which is then placed centrally in the formula load. The pellet indicates proper exposure conditions by melting and running down the tube only if time and temperature requirements are satisfied. This, it is claimed, is the only means of safe, simple measurement of requisite conditions inside the autoclave and inside the bottle.

For further information write to: Smith & Underwood, Royal Oak, Michigan.

* * * *

New Pamphlet Covers Care of Silverware

Of interest to hospitals, restaurants, and institutions using silver plated flatware will be a new pamphlet offered by McGlashan, Clarke Company, Limited. The pamphlet offers suggestions for the purchase, care, and handling of silver plated flatware and table cutlery to insure good appearance and long wear.

Points to look for when buying, as well as proper cleaning, polishing and repairing methods are covered in this excellent new folder, which will be a welcome reference for buyers and maintenance supervisors.

Any number of copies desired will be gladly supplied upon request directed to McGlashan, Clarke Company, Limited, Niagara Falls, Ontario.

* * * *

Moffats Limited to Manufacture Vulcan-Hart Gas Cooking Equipment

Under an agreement recently signed in Baltimore with Mr. W. M. Smock, President, Vulcan-Hart Manufacturing Company, Moffats Limited have the exclusive manufacturing and distributing rights in Canada, and production will start in January.

The Moffat-Vulcan and Moffat-Hart lines, as they will be known in Canada, will include complete gas cooking units, heavy duty ranges, roast and bake ovens, fryers, griddles, broilers and other specialty items. In manufacturing in Canada this American Gas Association approved equipment, Moffats will maintain the high standards of quality that have established Vulcan-Hart products as leaders in their field for the past sixty years. Many of the finest hospitals, hotels and restaurants in Canada over the years have installed this world famous line of gas cooking equipment.

NOW YOU SAVE UP TO 24% ON PHILIPS X-RAY EQUIPMENT

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The devaluation of British and European currency offers Canadian hospitals actual savings immediately.

Up to 24% . . . not less than 16% . . . on every type of X-ray Equipment from the great Philips laboratories in London and Eindhoven!

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Technicians acknowledge the superior quality of Philips X-ray units, precision-produced by the greatest X-ray laboratories in the world. They will see in this the opportunity to bring their departments to the ultimate in efficiency . . . at marked savings.

Many hospitals may wish to consider this investment under today's favoring conditions. Please write our Montreal Office of your requirements, and our nearest office will provide you promptly with complete information and prices.

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Keep pace with your requirements and means. Here is a basic self-rectified 100 Ma unit of handsome appearance and modern design ideally suited for the small hospital or X-ray clinic. When overtaxed departments or new techniques demand increased X-ray output, then change to full wave 200 Ma operation by the simple and inexpensive addition of a compact rectifier unit.

An improved electronic time-switch and mechanical technique-finder are examples of the many excellent features of this apparatus.

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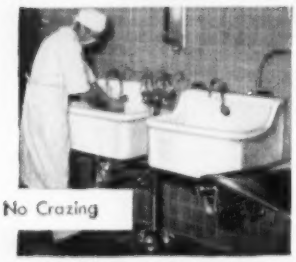

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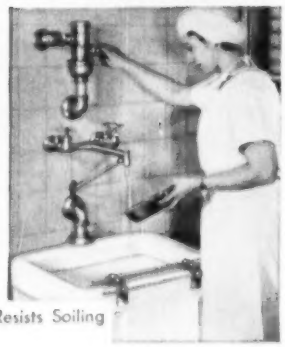

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Harvey Agnew, M.D., Editor

Toronto, February, 1950 Vol. 27 THE CANADIAN HOSPITAL No. 2

Obiter Dicta

Hamilton's "Citizen of the Year"

IT has been a pleasure to note that Dr. William I. Deadman of Hamilton has been named "Citizen of the Year" at the annual civic night dinner of the Advertising and Sales Club of Hamilton. In recognition of this honour he has been given the gold medal of the organization. Dr. Deadman is city and provincial pathologist and is director of the laboratories at the Hamilton General Hospital.

This honour will be noted with strong approval by Dr. Deadman's many friends throughout the country. Reports specifically mentioned his contribution in the field of diphtheria immunization and his work in developing the particularly fine blood bank at the Hamilton General Hospital—a department which he was loath to see discontinued. Many other interests could have been mentioned. A great imperialist, Dr. Deadman has given many fine addresses on the British Empire. The well established Canadian Society of Laboratory Technologists was given invaluable support in its early days by Dr. Deadman, without which support the Society would have had great difficulty in getting started. He was a leader in developing the Canadian Medical Association program for the approval of schools for laboratory technologists, which was worked out in co-operation with the C.S.L.T. Dr. Deadman has always kept in close touch with medical education and has represented the medical graduates for some years on the Senate of the University of Toronto. Despite a very busy program in his professional day, he has also managed to keep up his old military connections.

We recall that the signal honour which has been paid to Dr. Deadman was conferred on another hospital man a few years ago. Dr. Howard Holbrook was declared "Citizen of the Year" when he was superintendent of the Hamilton Sanatorium, an honour conferred largely because of the untold benefits of his progressive sanatorium policy to the citizens of that area; and also because of his many contributions to local and provincial activities in various fields. We have long held that a large proportion of our finest citizens are to be found in the hospital family and it is pleasing to note that other organizations agree with us.

Time makes Changes at the American College of Surgeons

THE announcement that Dr. Malcolm T. MacEachern is shortly to relinquish the directorship of the American College of Surgeons will be startling news to the many who think the two names are synonymous. For over thirty years Dr. MacEachern has been so closely associated with the College that most of those now in the hospital field will have no recollection of him as resident physician of the Montreal Maternity Hospital, or as superintendent of the Vancouver General Hospital. In his early years at the College, Dr. MacEachern was associated with the late Dr. Franklin Martin, founder and

director general of the College, and with Dr. Allan Craig, associate director, who is now in consulting work. Later, he and Dr. Bowman Crowell, a former Maritimer, carried on the work as associate directors. For several years now, since Dr. Crowell has not been so well, Dr. MacEachern has virtually been director of the College (a stupendous task), although the actual title was not conferred upon him until recently. It is only because of the increasing burden of the suicidal responsibilities which Dr. MacEachern has so willingly assumed that his friends on the Board of Regents have decided to let him concentrate on his consuming interest, the hospital program, and to have other hands direct the general activities of the College.

Everyone will be pleased that Dr. MacEachern is not leaving the College. Without question, it has been the greatest single factor in raising the level of medical organization and efficiency in our hospitals. Dr. MacEachern has been the key figure in this magnificent development and it would indeed be unfortunate if his wealth of experience were not still to be available to the hospital field.

We think this is a sound arrangement. Of prime importance, it will reduce the tax on Dr. MacEachern's strength, for not even his amazing vitality (built up behind the plough on an old Ontario farm) can carry such a load indefinitely. It will permit him also to give greater attention to his standardization program, to hospital meetings, and other hospital activities. There has been evidence now and then that the approval lists needed a little more checking than has been possible with a too thinly spread out staff. With more personal attention from Dr. MacEachern, it may well be that approval will mean what it is intended to mean, and that the great program of the College will go on to greater achievements.

Dr. MacEachern's successor as director of the general work of the College, Dr. Paul R. Hawley, brings to his new duties a wealth of executive experience. Dr. Hawley has displayed unusual powers of leadership as Chief Surgeon of the European Theatre of Operations in World War II, as organizer and director of the Department of Medicine and Surgery, Veterans Administration, and more recently as Chief Executive Officer of the Blue Cross and Blue Shield Commissions. We anticipate for him a full measure of support and co-operation in his new responsibility.

More Hospital Fires

TWO more serious fires in hospitals, one in an American psychiatric division and one in our own far North, have again called attention to the ever-present danger of fire in a hospital. The former presented a particular problem. Having the windows arranged for the protection and detention of mentally deranged patients added immeasurably to the difficulty of rescuing the inmates and undoubtedly increased loss of life. (See page 29.)

Government and municipal fire authorities are tightening regulations considerably and we understand that plans for new construction are being checked more carefully than ever for fire-preventive and quick egress features. The *Noronic* tragedy has focussed attention, too, on the ease with which fire spreads, on the importance of having equipment in good order and of having personnel drilled in the procedures to be taken. This disaster also called attention to the necessity of having emergency facilities ready to handle unusual situations should there be a disaster somewhere else and victims be brought in for treatment.

In our next issue, we shall make reference to an important conference on civilian disaster planning which was held at the Canadian Red Cross headquarters and in which a number of national health organizations (including the Canadian Hospital Council) and the federal government participated.

While fires may, and do, occur at any time of the year, there seems to be unusual danger at this season, especially in smaller or older hospitals where the heating system may not be as modern as it should be. This is the time, too, when shorter days and cold spells mean more use of electricity and, in some cases, greater use of portable heaters. Changing personnel makes it difficult to enforce regulations or ensure intelligent action in case of fire. Everlasting vigilance is the price of safety.

The Antihistamine Hysteria

IT was but to be expected that the wild rush of pharmaceutical houses to get on the antihistamine band-wagon, and the equally wild rush of the public to pour golden shekels into the coffers of these companies, would elicit sharp reactions. Apparently there is evidence that in some instances the allergood symptoms characteristic of a beginning cold have been alleviated or ameliorated by antihistamines, but this frequently happens with other treatment, or no treatment, and much careful study will be necessary to ascertain their exact effect on the common cold. Little is known yet of the after-effects of extended antihistamine ingestion. The Federal Department of Health and Welfare has warned persons not to exceed the recommended dosage nor to take the drugs over a long period except under a doctor's direction.

Drowsiness is one common effect which may be serious in the case of a motorist or one operating machinery. Last month a young woman in Toronto slept some seventeen hours after taking these tablets. The Federal Department noted that while these drugs appear to be useful in the treatment of allergies, colds are still thought to be due to a virus infection and there is no evidence that antihistamines have any effect on the virus. The A.M.A. Council on Pharmacy and Chemistry has more than once warned of the effects of this drug and stressed that we do not know what the effects of prolonged usage may be. Particularly does there seem to be a risk in advertis-

ing them as safe and harmless, with their use for children featured in advertisements.

In its January issue, *Consumer Reports* reviews the scientific studies to date. It takes a more objective and reserved viewpoint than did de Kruif in his ballyhoo for treatment by antihistamines in the *Reader's Digest* (Dec., 1949). Unfortunately neither de Kruif nor that magazine would seem to have gained the confidence of the medical profession, perhaps because of a tendency to accept too readily what still requires much careful checking to warrant professional acceptance. At any rate the drug houses in flamboyant advertisements, building up what *Consumer Reports* calls "a $100,000,000 market", have given both the *Reader's Digest* and de Kruif priceless advertising. One company, after the first announcement, was reported to be selling thirty million tablets a week.

A few drug companies are not making antihistamines for sale over the counter. The Ciba people have stated that they "do not believe that the oral forms of pyribenzamine or any other antihistaminic should be made available to the general public without prescription". Frank W. Horner Ltd., in a circular letter to the medical profession, states that there will be no Horner cold remedy because the product is not suitable for ethical promotion. Few people will be far-sighted enough to seek medical advice on the choice of anti-cold tablets; the big movement will be over-the-counter sales of products nationally advertised via newspapers and radio. However, to assist physicians lost in the jungle of new trade names, this company has distributed a list of the trade name preparations, their content and makers.

Dr. L. O. Bradley to Become C.H.C. Executive Secretary

THE Executive Committee of the Canadian Hospital Council has announced the appointment of Dr. Leonard Bradley to succeed Dr. Harvey Agnew as Executive Secretary of the Council and as Editor of *The Canadian Hospital*. He will assume his new duties when Dr. Agnew relinquishes that post in July to enter the field of hospital consultation.

Leonard Orville Bradley was born at Neudorf, Saskatchewan, where he received his elementary education, later attending Luther College in Regina. He was graduated in medicine from the University of Alberta in 1938 and served a graduate internship at the Royal Alexandra Hospital, Edmonton. In 1939, Dr. Bradley was awarded the Mead Johnson Fellowship in Paediatrics at the Minneapolis General Hospital and continued on to a second fellowship in the same field at the University of Minnesota Hospital in 1940. For the next five years he served as a medical officer with the Royal Canadian Air Force at command headquarters in Winnipeg, and in hospitals of various sizes from Fort William to Victoria. On retiring from the Service, he was mentioned in dispatches as official recognition of his excellent work.

In 1946, Dr. Bradley served as assistant to Dr. A. F. Anderson, then superintendent of the Royal Alexandra Hospital, Edmonton, following which he enrolled in the hospital administration course which is under the direction of Dr. A. C. Bachmeyer at the University of Chicago. On graduation, he was appointed Associate Professor of Hospital Administration at the University of Toronto, a position which he still holds on a part-time basis.

Leonard O. Bradley, M.D.

Under the direction of Dr. Malcolm T. MacEachern, and on behalf of the American College of Surgeons, Dr. Bradley spent several months in survey work in Ontario during 1948. Later he became Director of Studies for the Ontario Health Survey Committee under the chairmanship of Mr. G. D. Davis. He is a nominee of the American College of Hospital Administrators and holds personal membership in the Ontario and American Hospital Associations.

Dr. Bradley is married to the former Miss E. Mona Bounds of Edmonton and they have two children, Leslie Ann, age seven, and Billy who is four.

In commenting upon the appointment of his successor, Dr. Agnew said, "The appointment of Dr. Bradley to this position is most fortunate. He has an unusual knowledge of hospitals and their problems. His extensive clinical training, executive experience, and formal training in hospital administration, form an excellent background for his new work. In addition, Dr. Bradley is conscientious, hard working, and a man of ideas. The hospital field in Canada is fortunate in the Executive Committee's choice and I am sure that 'Brad.' will be given a warm welcome by all."

Some Aspects of

Food Poisoning

Part I

George W. Peacock,
M.D., D.H.A.,
Kingston General Hospital,
Kingston, Ont.

WHILE food poisoning is not in any sense of the word a national problem, to those who prepare and serve institutional food it is an ever-present and potential possibility. In the hospital field the superimposition of this illness on the sick or convalescent offers further abuse to their already disturbed physiology and embarrassment to the administrative and medical staffs. Only by a thorough understanding of the entire problem of maintaining continuous and adequate supervision in the dietary department and having a well-trained dietary staff can it be checked.

Attacks of food poisoning may occur at varying lengths of time following the consumption of contaminated food and frequent reference to such situations are to be found in the literature. Two such situations occurring in hospitals are referred to in publications listed below.[1, 2] In the first case, 330 persons became ill and in the second 40. Consideration of situations such as these tends to emphasize the gravity of the problem if it should arise in your institution.

The dependency of one's health on the quality and quantity of food is obvious. To avoid food spoilage and food-borne disease, sanitary and efficient methods of food production, transportation, storage, and final food handling services, are also quite obviously required and so must at all times be assured to those who place themselves in one's care. Of equal importance is the recognition of the particular dangers associated with certain types of food (e.g. mushrooms), the accidental introduction of poisonous substances (insecticide sprays, cyanides in some silver polishes), or the increased risk attendant on the use of foods (particularly those high in protein content) prepared and kept in such a way as to enable any organisms that have gained access to them to multiply (cream fillings, ground meat, et cetera).

Allergies

In the broad sense of the term, food poisoning may be defined as any illness coming on after the ingestion of any contaminated food or drink. While this definition does not include illness associated with allergy it would appear that some mention should be made of this form of hypersensitivity to certain foods exhibited by some people and not by others. The manifestations of this condition may vary with the individuals concerned, giving rise to gastro-intestinal upsets (colic, diarrhoea), migraine, asthma, "hay fever", skin eruptions or other complaints. In the mind of the lay person suffering from a distressing attack of dermatitis, a strong suspicion that he has been poisoned by food often exists, unless care is taken to point out carefully the mechanism of the complaint. It is now generally accepted that approximately 10 per cent of the population show some evidence of allergy to one or more substances during their life, and this suggests that it is a factor to be considered in evaluating individual complaints. Crisp[3] states that foods most often at fault are milk, eggs, cereals, fresh nuts, spices and some vegetables, i.e., a number of our most common foods.

Chemical Poisons

Chemical poisons in certain specific foods not included in the above definition should be noted in passing. Perhaps the most familiar example of this type is mushrooms. As the majority of us are not sufficiently expert to distinguish the edible from the poisonous varieties, it is imperative that their source of supply for institutional use be restricted to recognized commercial growers or canners. Rhubarb leaves in contradistinction to the leaf stem may cause illness, and likewise the green parts of white potatoes frequently contain enough solanine to cause severe illness and even death. The animal food most often responsible for illness is mussels from the Pacific Coast containing a poisonous alkaloid which may induce gastro-intestinal disturbance.

Food may become contaminated by the accidental introduction of foreign chemicals in various ways, or by chemical action during preparation. Agate and aluminum cooking utensils have ceased to be considered dangerous to health, but most agree that glass containers are preferable for prolonged cooking or storage of highly acid foods such as tomatoes or rhubarb. Cadmium on the other hand when used as a substitute for aluminum in cooking utensils is recognized as having induced gastro-intestinal disturbances at times.

Occasionally poisoning may follow the ingestion of carelessly washed fruits or vegetables that have been sprayed (lead, arsenic) by the producer, as a protection against insect pests and mould. Illness associated with cider made from unwashed apples is a similar condition. While these are admittedly rare possibilities they have occurred and as such their re-occurrence or existence must be taken into consideration.

Sometimes poisons such as cyanides are used in silver polishes and enough cyanide may remain on an incompletely washed fork to precipi-

1. *Lumsden, L. L., Nau., C.A., and Stead, F. M.: "A Study of an Outbreak of Food Poisoning in a Hospital in Galveston, Texas." Public Health Reports 58: 1947, 1943.*

2. *Rutherford, R. S.: "Two Epidemics of Staphylococcal Toxin Food Poisoning." J. Can. M. Serv. 2: 473, 1945.*

3. *Crisp, L. H.: "Essentials of Allergy". Lippincott, 1945.*

tate a severe illness or a fatality. Another possible accidental source of contamination is that associated with virus or bacterial poisons used for pest control. In one college outbreak in the United States over 100 people became ill following its use as a rat poison. It is imperative then, if this type of pest control is used, to avoid its use in or near places of human habitation.

The recent popularity of D.D.T. has increased the hazards of possible food contamination. Sprays containing this solution must be prevented from coming in contact with food, utensils, or surfaces used for food preparation. D.D.T. is a poison and should be so treated. In its powder form D.D.T. has been confused with flour and baking or milk powders and usually with ill effects as one teaspoonful is probably the lethal dose for man.

Boric acid, so often found in the formula rooms of hospitals where it is used as a mild antiseptic in cleansing rubber nipples, may be an accidental source of poisoning. Most people consider it to be harmless but deaths attributable to it have been reported in the medical literature. In a recent report of such an occurrence it was apparently used in error for sterile water and added to a formula being prepared for infant feeding.[4]

Disease Producing Organisms

Food poisoning due to disease producing organisms is the type with which most of us are familiar. A wide variety of causative factors exists ranging from tapeworms to a virus. Transmission may be from animal to man or man to man, with or without other vectors such as the common housefly. Among the commonest human diseases known to be transmitted through food are: diphtheria, the common cold, tuberculosis, undulant fever, worm diseases, scarlet fever, septic sore throat, amoebic or bacillary dysentry, typhoid or paratyphoid fever, and enteritis due to staphylococcus or streptococcus toxin.

Botulism in man has been traced to animals (lumberneck in chickens and keel disease in ducks) but its transmission is usually through vegetables contaminated by soil rather than animals. Botulism, since the introduction of modern commercial canning processes and the relative decrease in home canning, has greatly declined in its incidence and now rarely occurs.

Ptomaine poisoning (Greek ptoma, a dead body) is a term often falsely

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4. E. G. Young, R. P. Smith, O. C. MacIntosh, "Boric Acid As a Poison." C.M.A.J. Nov., 1949, P. 447.

Dr. A. Lorne C. Gilday Retires

AFTER a long and distinguished career in hospital administration, A. Lorne C. Gilday, M.D., C.M., D.S.O., retired as of last month from his position as superintendent of the Western Division, Montreal General Hospital. Dr. Gilday has been associated with that hospital since his graduation from McGill when he was appointed to the resident medical staff. During World War I he went overseas as medical officer of the 87th Battalion and in 1917 was appointed officer commanding the 13th Field Ambulance with the rank of lieutenant-colonel. He was awarded the Distinguished Service Order for valour in the field and, having been wounded, returned to Canada in 1918, where he served as Assistant Director of Medical Services until his demobilization in 1919.

In 1923, Dr. Gilday was appointed superintendent of the then Western Hospital and, upon its amalgamation with the Montreal General in 1924, he continued as superintendent of the Western Division. During World War II, he served the hospital as acting general superintendent for three years. In paying tribute to Dr. Gilday, Major S. C. Norsworthy, President of the Montreal General Hospital, spoke as follows:

"Dr. Gilday has at all times kept in mind the hospital's long tradition of service and, in continually acting in its best interests, has done much to enhance its reputation. . . Imbued with a keen sense of duty and loyalty, he has carried out his responsibilities faithfully and conscientiously. He is highly respected and esteemed, not only by the staff of the hospital but also by his colleagues and many friends whose hope it is that he will enjoy his well deserved rest for many years to come."

As Secretary of the Montreal Hospital Council, a post which he has held since 1926, Dr. Gilday has played a major part in co-ordinating the policies and activities of its member hospitals. From 1941 until 1943, he was vice-chairman of the Quebec Hospital Commission and since 1946 he has been the very capable Treasurer of the Canadian Hospital Council. He will continue to serve the Montreal Hospital Council and also to act as Treasurer of the national body. Since Dr. Gilday now has more leisure to devote to these activities, the larger hospital field may well benefit even further through his constant energy and sage advice.

It has been, we understand, Dr. Gilday's custom throughout the years to go riding on the "Mountain" every morning promptly at 6 a.m. Questioned as to whether he would continue that Spartan regime, he replied that while he might prefer to go out a little later he had found that sleeping in was simply demoralizing to his horse.

A. L. C. Gilday, M.D.

Are We in Danger of Building
Too Many Beds?

John McGilp,
Assistant Director,
Division of Hospital and Medical Services, Dept. of Public Health, Alberta.

WE speak of bed capacity and bed complement practically every time that we discuss hospital statistics. *Bed capacity* means the number of hospital beds that can be established in the hospital in accordance with the minimum space requirements and in areas designed for the accommodation of beds. *Bed complement* means the number of beds actually set up regardless of space requirements and space in which they are established. In most cases, therefore, bed complement exceeds bed capacity. Bed complement fluctuates as the load changes, but bed capacity is constant until alterations to the building are made.

Bed occupancy is another term often mentioned. It refers to the percentage of the average patient day load in the hospital, for any given period of time. Occupancy is calculated on the basis of daily patient day load as against the bed capacity of the hospital. Most experts recommend 70 per cent as being the desirable and most economical bed occupancy. Reference is also made to beds per thousand population and patient days per thousand population, and bassinets and newborn days are invariably excluded when discussing these two ratios. In other words, when we speak of so many beds per thousand population, we refer to adult and children's beds only, and when we speak of patient days when calculating the potential load of any district, newborn days are omitted.

The latest statistics available for the existing bed situation are for the year, 1948. In 1944, it was reported that there were 7.5 beds per thousand population in this province, in 1945 there were 6.1 beds, in 1946, 6.4 beds, in 1947, 6.3 beds and in 1948, 5.9. The explanation for the apparent discrepancies in these figures is simply the different methods used in counting beds. In 1944 bassinets were counted as beds. This accounts for the high ratio of 7.5. Furthermore, hospitals for many years have been reporting bed complement as their bed capacity, which results in more beds per thousand population being reported than is the actual case. The situation is being gradually corrected, as hospitals are being rated by the Medical Inspector of Hospitals.

On December 31, 1948, there was a total of 4,903 beds in the approved hospitals of this province. This gives a ratio of 5.9 beds per thousand population. These beds accounted for 1,345,265 patient days, giving a bed occupancy for the province of 75.1 per cent. When we exclude special type beds, such as D.V.A. beds, tuberculosis, and orthopaedic beds, we have 4,290 beds which is 5.2 per thousand population, with 1,206,379 patient days, giving a bed occupancy of 77 per cent, which is seven per cent more than the experts recommend.

The Immediate Future

Financial assistance is now available, through the Dominion-Provincial health grants, for the construction of additional hospital beds. This naturally has resulted in many new hospital beds being provided either in new hospitals or in additions to existing ones. Since December 31, 1948, approximately 1,600 additional active treatment beds have been, or are being, provided. Adding these new beds to the 4,290 available at the end of 1948, we find a total of 5,890 active treatment beds, excluding those special type beds, or a ratio of 7.1 beds per thousand population.

In addition to these 1,600 new beds, we have on file applications from many more hospitals and communities for the construction of hospital beds. There are, as well, hospitals and communities which have not as yet made application, but which are seriously considering doing so. How many beds would be provided in this group it is hard to say, but an estimate of 1,000 would be conservative. If these beds are constructed within the next two or three years, we would then find ourselves with a total of 6,890 active treatment beds, or a ratio of 8.3 per thousand. This would again be exclusive of special type beds. Should we bring them back into the picture, we would then have a total of 7,503 and a ratio of 9.0 beds per thousand population. The obvious question is, what would happen to our bed occupancy? In 1948 it was 75.1 per cent based on 5.9 beds per thousand; what might it be if based on 9 beds per thousand? Will the patient day load increase to maintain the occupancy at the economical level of 70 per cent or will the occupancy drop to the costly level of less than 50 per cent?

In order to arrive at some solution to this problem, we must consider the demand for additional beds. The demand seems to appear chiefly in the "waiting lists" that most hospitals carry at some time during the year. In this province, the demand is highest in the first three months of the year. When the elective surgical case is told that there is no bed available at the present time, a cry for more beds is almost immediately heard from the public. Yet we cannot base our bed requirements on the peak load; the cost would be prohibitive. What measures then, should we use to assess our bed requirements?

There are many factors that must be taken into consideration in this question, such as changing conditions and habits. One generation regarded admittance to a hospital as an unusual event; the next generation looks upon

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From an address given at the Associated Hospitals of Alberta, Nov. 2 to Nov. 4, 1949.

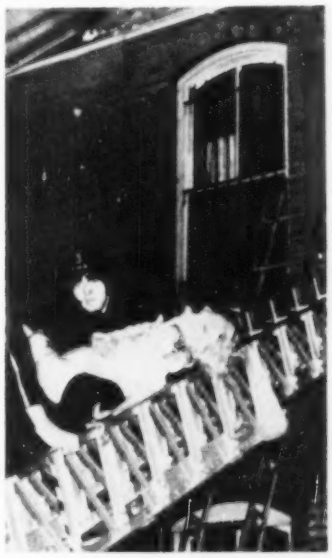
Wide World Photos

Fire Demolishes

Psychiatric Unit at Davenport, Ia.

IN the early morning hours of January 7th, fire of undetermined origin raced through a mental ward building on the grounds of Mercy Hospital, Davenport, Iowa, resulting in the death of 41 of the 65 patients and one nurses' aide. It was indicated by the fire chief that the blaze had started in a room on the east side of the ward, spread into the hall, up a dumb-waiter shaft, and over the top of the building. In less than two hours, only charred and smouldering ruins remained.

Known as the St. Elizabeth ward, the three-storey structure was about 60 years old. Parts of it had recently been remodelled and all partitions were acceptable according to modern building codes. However, the fire was far advanced before it was discovered about 3 a.m. and several conditions combined to hamper fire fighters. The temperature was down to 14 degrees above zero and a high wind fanned the flames. Window bars and steel mesh, essential in the care of mental patients, prevented them from escaping through windows and also seriously handicapped rescue work and fire control effort. There were two fire escapes and two other exits, all of which were locked because of the nature of the medical service. An automatic sprinkler system had been recommended but had not yet been installed.



A fireman carries one of the victims from the blazing building.

The sheer horror inherent in this tragedy should emphasize the obligation of hospital authorities to provide every possible protection against the hazards of fire.

Hospital for Sick Children Benefits by Hammell Will

The Hospital for Sick Children, Toronto, will receive some $450,000, under the will of Mrs. J. E. Hammell, wife of Jack Hammell, well-known mining magnate.

Mrs. Hammell died last Dec. 6, and her will was probated recently. Practically her entire estate was directed to the hospital. The money, it was specified, was not to go into the building fund but to be used in the endowment of hospital beds in her name.

Occupational Therapy and the Active Treatment Hospital

H. Hoyle Campbell, M.D.,
President, Canadian Association of Occupational Therapy, Toronto, Ont.

DURING the past thirty years, occupational therapy has taken its place among those professions prepared to assist in rehabilitating the injured and diseased, both mentally and physically.

At first, it had its greatest field of activity in the psychiatric and crippled children's services, as the medical specialists interested were quick to realize its value. More recently, other organizations interested in trauma, tuberculosis, geriatric medicine, and arthritis, have come to realize that occupational therapy, properly used, is of great benefit in the treatment of their convalescent patients.

As there are, annually, approximately 15,000 persons in Canada who require some form of rehabilitation, it is not surprising that this whole subject should become important. The establishment of national organizations for the stimulation of proper management and rehabilitation of arthritics, paraplegics, and so on, have given further impetus to the development of occupational therapy.

Total Rehabilitation

Total rehabilitation has been defined as "the process of assisting the disabled to attain the optimal physical, mental, social, economic, and vocational adjustment and usefulness of which they are capable".

As the medical profession is saving the lives of more and more of the severely injured or diseased, greater numbers of disabled persons are accumulating in the country. Add to these the increasing numbers of aged persons, and those suffering from the crippling arthritic and cardiac diseases alone, and the community responsibility in welfare becomes tremendous.

The greater the time lapse between the onset of the disease or injury producing the disability and the beginning of the rehabilitation program, the less effective it is. Rehabilitation is a complete process and should begin with the diagnosis, or as soon after as it is practicable.

The Baruch Committee divides total rehabilitation into medical, vocational, and social. Medical rehabilitation is "the restoration of people handicapped by disease, injury or malformation, as nearly as possible to normal physical and mental state". The other two include retraining and re-educating that they may become employable, if possible, and restored to a suitable family life.

In the general hospital it is medical rehabilitation that is so important, the other two may be started but would, of necessity, have to be continued in the out-patient clinic or at separate civilian rehabilitation centres, the patient living at home. The welfare agencies would, under such a plan, take over the responsibility for management, but the doctor should continue his supervision throughout.

Because of the continuous nature of the process, the services of doctors, nurses, physical and occupational therapists, psychologists, prosthetic services, public health nurses, sociologists, vocational and retraining workers, and others, must be co-ordinated.

Total rehabilitation, then, is considered from the viewpoint of the individual, who might require all,

Early occupational therapy. Patient has lost a major portion of the calf muscles from initial injury. Therapy is designed to mobilize knee and strengthen the muscles controlling it.

some, or none of the services available, to solve his particular problem.

Place of Occupational Therapy

Occupational therapy is a definite part of this plan, and if properly directed and integrated can be of great service. Merely sending a patient to the department is not enough. The doctor must outline the nature of the disease, the prognosis, and what it is he anticipates that the patient may eventually be capable of doing. If he does not know himself, the specialist in physical medicine may be able to assist in this.

The occupational therapist is trained that she may assess the motivation and abilities of the patient, so that special supervision may be brought to him before it is too late. It is at this stage that psychiatry can help most; not later when the pattern has become so firmly established that many of the problem cases are insoluble.

It has been shown in Great Britain that malingering is most often a sign of poor medical management and can be by-passed early in the disease through proper attention to these principles.

Medicine in the past has been primarily concerned with the diseased part or organ of man's body, often to the exclusion of the *whole* man. On the other hand, some psychiatrists look upon the patient in terms of his personality, character and so on, and neglect the physical disease. Either of these approaches to the problem is bound to antagonize the patient or neglect some important aspects of his illness.

The services of the doctor, the nurse, and the physiotherapist, have been integrated to some extent in "part" treatment in the past ten years; but there has been some lag in utilizing the remaining essential services. The relation of the ophthalmologists and the Canadian National Institute for the Blind is an ideal example of good rehabilitation.

While it is known that about 10,000 to 15,000 voluntary muscle contractions are necessary to keep a part of the body normal—how many do our own hospital patients do? Very few, I would say, if it is left to them—a few hundred, if it is left to the physiotherapist. If we interest the patient, however, in an occupation designed to exercise the injured part and at the same time make him co-ordinate its action, the number of contractions will be substantially increased. The interest created alters the mental outlook from one of introversion to objective thinking. This, the psychiatrist stresses.

Occupational Therapy later in rehabilitation. Type of O.T. for fracture of femur with peroneal palsy—to mobilize and strengthen knee action, foot and leg action. Note concentration of the patient.

A man is, let us say, normally employed as a lathe operator, and suffers from a knee disability. Post-operatively, in due course, he begins his physiotherapy of massage, heat, and active resisted exercises. Then he graduates to such an appliance as a bicycle-powered lathe and is instructed to design some object. His knee is put to use driving the instrument, while his whole body co-ordinates in the action of carrying out his project. Active resisted exercises of his knee are continued after his physiotherapy has prepared the stiffened knee for action.

Relationship to Physiotherapy

Where does physiotherapy end and occupational therapy begin? Ideally they overlap, the one augmenting the treatment of the other. This produces at an early phase of the patient's care, good medical rehabilitation. In addition to mobilizing the injured part, the man "keeps his hand in" at his work. Time does not hang so heavy on him that worry and fear of the future are allowed to instigate a varying measure of psychological disturbance.

While it is true that not all patients require such management, many do. As society is interested in all people, not just the best motivated people, we must strive to assess this motivation and the abilities of our "cases" as early as possible. It is the occupational therapist who can do this.

While vocational and social rehabilitation may be required, attending vocational guidance personnel and sociologists may, with the information at hand, work to provide possible solutions to a patient's problems before his psychological deterioration makes the task impossible.

Welfare agencies are anxious to see such co-ordinated programs, and arrangements might be made to tide the family over, financially, until the retraining and re-establishment are completed.

The administration of the general hospital would be called upon to set up a physical medicine department that its services might be available, as are those of the radiology department, for the in-patient. Such co-ordinate medical rehabilitation would

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Some Problems Common to SMALL HOSPITALS

Percy Ward,
Executive Secretary,
British Columbia Hospitals' Association.

ONE of the reasons why problems are more difficult and generally more disturbing to personnel in the small hospital is that this type of hospital has neither the staff nor the volume of work which compels the large hospital to plan and organize more thoroughly and in more detail. A large hospital has at least two advantages in the prevention and in the handling of problems. It has a larger staff and can break the work down into greater detail, thereby achieving more facility in the performance of specific duties.

More careful planning of the organization of a small hospital is needed. There is a tendency on the part of some small hospitals to think that the close personal contact of members of the staff makes organization and the specifying of duties unnecessary. Hospitals taking this attitude generally contend that the staff has so many things to do, as it is, they have not time to plan and put their thoughts on paper. And while such a hospital is contending that this is so, staff members are sometimes running around in circles worrying about problems that would not have arisen if proper planning had been inaugurated.

There are problems which cannot very well be anticipated. But there are also those which can be avoided; and it is usually these latter ones which create major disturbances among the personnel—and among the members of the board of management, too. In many of the small hospitals which I have visited, most of the disturbing problems have arisen between the board of management and the doctors, or between the superintendent of nurses and either the doctors, the hospital board, other members of the permanent staff, or in connection with visitors and visiting.

From an address at the 1948 Western Canada Institute for Administrators and Trustees, Regina.

Involving Medical Staff

Most of the difficulties in which practising physicians are concerned can be avoided by organizing the medical staff and filtering all questions which affect the doctors and their work through medical staff meetings. To try to operate a hospital without organizing the medical staff is like starting out on a journey in an automobile with three tires, trusting to the fourth wheel to carry the car on its steel rim. You know you will have a bumpy trip that way.

Of course, the work that can be carried out by the medical staff of a small hospital is very limited in comparison with that of the large hospital. But, no matter how small the hospital, the framework of a medical staff organization should be arranged and followed, even if there is only one doctor in the locality, or if the two or three doctors practising in the hospital are partners. There are many reasons why such an organization, operating actively and meeting once a month, can be of great value to a small hospital. Let me give you just one reason.

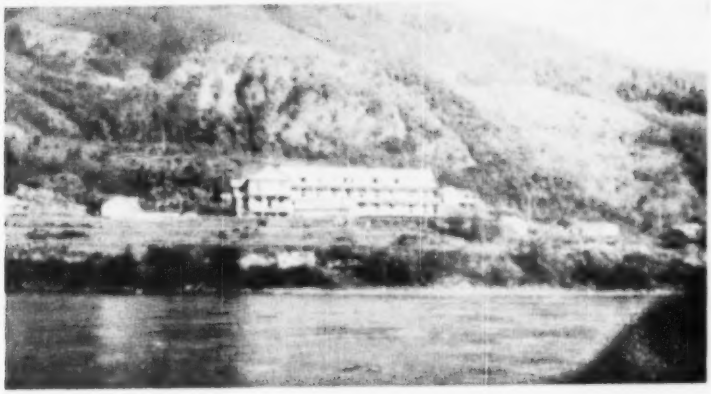
The best way to avoid problems is to look ahead and to plan ahead. The secret of smooth operation and of all success is intelligent anticipation.

Do you nurse-superintendents and matrons sometimes have difficulties with your doctors? Are not many of these difficulties centred around the action you have taken, or have failed to take, with respect to suggestions or requests from individual doctors? We are referring to requests which, if turned down, will arouse resentment in the doctor turned down or if granted will arouse resentment on the part of the other doctors who may accuse you of favouritism. The best way to avoid a difficulty here is never to give hurried personal decisions on such matters. When you receive a request of this nature, you might say to the doctor as sweetly as you can, "That probably is a good idea but it is a matter which may affect other doctors, so will you kindly place your suggestion before the medical staff at its next meeting? If the meeting recommends it, it will probably be carried out". You can get around your most troublesome and disturbing problems with doctors by following this procedure. One good way to avoid antagonizing individual doctors practising in the hospital is to treat all doctors alike. The best way of doing this is to filter all their important requests through their own organized group, namely, the organized medical staff of the hospital.

Involving the Board

May I ask, secretaries and nurse-superintendents of small hospitals, has your hospital board, without asking your views or giving you an opportunity of making recommendations, ever passed a resolution requiring something to be done which, in your opinion, would be disruptive to the work of the staff or of the normal procedure through which the work of the hospital is carried on? If so, how did you handle this problem?

I suggest to you that there is an obligation on the part of the secretary-manager or the superintendent to place his or her views before the board on all matters affecting the organization where a decision of the board is necessary. This should not be done by arguing with the members at a board meeting, but should be done in writing. You, as superintendent or secretary-manager, are supposed to assist the board in the



St. Mary's Hospital, Dawson City, Yukon.

Historic Hospital of the Far North Laid Waste by Fire

ST. Mary's Hospital, Dawson City, Yukon, one of the oldest and most vital institutions in that district, was burned to the ground on January 10. The hospital was founded by Father William Judge and the Sisters of St. Ann during the Gold Rush Days. It began as a two-storey log structure, hastily erected in an attempt to relieve the distress and suffering of the hundreds who braved a rugged land in search of wealth and adventure. It developed into a modern, well-equipped hospital accommodating 100 patients and serving a large area. Just two years ago, St. Mary's was honoured in the celebration of its golden jubilee.

Fire broke out at 1.30 p.m. Doctors, nurses and orderlies hurriedly wrapped 77 patients in sheets and blankets and carried them outdoors. Thirteen tuberculosis cases were sent to Whitehorse by plane. The rest of the patients and sisters found shelter in school buildings and hotels. The three-storey Occidental Hotel was opened as a temporary hospital.

Sister Mary Gedeon, who had served St. Mary's from the early days, lost her life. She was a patient in the infirmary on the second floor where the blaze originated. Another nun was seriously burned when she made heroic efforts to salvage valuable equipment that might take weeks or possibly months to replace.

Members of the Dawson fire department and scores of volunteers fought the raging blaze all afternoon, battling against terrific odds. The thermometer registered 40 below zero. Icy arctic winds whipped flames high into the air and water from high-pressure hoses froze as it hit walls and windows.

Damage exceeded $100,000, while loss to the community is incalculable.

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light of your detailed knowledge of the organization and of the happenings that occur from day to day. A great deal can be conveyed by you to the board verbally where it is appropriate for you to speak. But in matters that are likely to be at all difficult, where there may be a division of opinion, or where the subject may be contentious, you should sit down and, as briefly as possible, set out in writing an outline of the problem and make a clear and definite recommendation as to what you think should be done.

If the board has, without consulting you or without giving you a chance to make a report, actually ordered something which you think unwise or wrong, write and ask the board to reconsider its decision and *give good reasons why you make the request*. Carefully written reports, courteously composed and placed before the board, will often prevent problems from arising and will sometimes remove them after they have arisen. Give the members a chance to study your report before the meeting if the matter is complicated and requires careful study. Remember this: if after receiving your report the board turns you down, your views and recommendations are on official record in writing and, if anything goes wrong later, the board will have to accept full responsibility for it. But if you do nothing except, perhaps, grumble to anyone who will listen to you, you may be disturbed later to find that, if anything does go wrong, you are held to blame.

Visitors

It is wise, especially in small hos-

pitals, to have all visiting hours considered by the medical staff at a regular meeting. They should be recommended by the medical staff and approved by the hospital board. The ability to indicate on the notice that visiting hours have been "Recommended by the Medical Staff" and "Approved by the Board of Management" will help materially with certain visitors who are difficult to handle. Take the case of the visitor who, out of regular visiting hours, wants to see a certain patient and claims that Doctor "So and So" gave him or her permission to do so. The nurse hearing this may have to decide on very little evidence whether to believe the visitor or incur the displeasure of the doctor in question. When visiting hours are officially marked as being recommended by the medical staff (which means all the doctors as a group), no one doctor can contravene such recommendations with impunity and, in any case, he cannot justifiably criticize the nurse for carrying out the printed instructions of his colleagues in the profession.

The Constitution and By-Laws

The constitution usually sets out in general terms the purposes of the organization. These general terms should later be amplified by the hospital board through by-laws and regulations so that the executive staff of the hospital may not be in doubt as to the purposes and limits of responsibility which the hospital accepts. A frequent cause of problems in small hospitals is the lack of specific definition of the purpose for which the hospital is established and the type of patient it should accept, and failing to recognize the limitation of its facilities. Boards of small hospitals need expert advice on this. Such advice can usually be obtained by consulting the management and the medical staff of a larger central hospital within the area. Not knowing what one is supposed to do, or where one is supposed to be going, is an invitation to difficulties and to disturbing problems.

Board Membership

The constitution or the by-laws of a hospital set out the manner of appointing and electing the members of the hospital board. It is here we often find the seeds of subsequent trouble. Subject to the fact that the owners and operators of a hospital should have a majority of representatives on the board, it is, in my opinion, a grave mistake to provide for the appointment to the board of any person selected by and representative of any other organization. This does not mean that the member of another organization should be excluded, but that such a person should not be appointed by the other organization so that he or she has a responsibility to cater to the interests of anyone other than the hospital and its patients. It is unfair to such a person because, in the course of hospital administration, questions often arise in which there are clashing interests. No board member should be put in the position of having to vote against the interests of the hospital in order to secure some privilege for, or to cater to the special views of, the group or organization responsible for his or her appointment to the board. The owners of a hospital have the right to dictate the policy of the hospital.

The board of management is the supreme authority in a hospital. Its attitude and unity of perspective towards and in connection with the hospital are vital to the smooth and efficient running of the institution. To encourage divided interests on the board is like building a house on an unstable foundation; the result is likely to be a twisted and warped superstructure.

I have heard it suggested that the best type of person to elect to the board is one who is skilled in some profession or activity which may be useful to the hospital. I disagree with this view. I know of nothing more disastrous to that unity of purpose which is the main characteristic of the successful hospital board than to have members who think they know more about some phase of hospital operations than do the regular members of the staff whose duty it is to attend to these matters. The fact that no member happens to be a con-

PROTEST

From information received by the Canadian Hospital Council, it is obvious that it is the overwhelming opinion of the hospital field that the hospitals of Canada should not be brought under the provisions of the Unemployment Insurance Act as is presently under consideration by the Commission.

The Canadian Hospital Council is protesting this proposed extension of coverage. Officials of the Department of Labour have been consulted and officers of the Council discussed the matter with the Honorable Mr. Paul Martin, Minister of National Health and Welfare, in Ottawa on February 3rd.

Extension of coverage would mean an added expense of hundreds of thousands of dollars to be borne equally by hospitals and hospital workers. Since hospitals are non profit organizations without reserves they would, necessarily, have to look for increased revenue through charges to patients in order to meet their share of the cost. Hospital employees, on the other hand, would contribute substantial sums to the fund through payroll deductions while, due to the stability of their employment, there is little likelihood of any benefit accruing to them. For competent workers, there is no unemployment in the hospital field.

Before making a specific recommendation to Parliament for an amendment to the Act the Unemployment Insurance Commission has invited interested persons to make representations (Canada Gazette, January 28th, 1950). The Canadian Hospital Council will present a brief on behalf of the hospitals of Canada setting forth the hospital viewpoint as received from member Associations and Conferences. Representatives of the Canadian Hospital Council will appear before the Unemployment Insurance Commission at a public hearing on February 24th.

The Hobby Corner

19. Winnifred Miller

THAT one does not need to live at the seaside or near the mountains to achieve fame in photography has been shown by Miss Winnifred Miller, the photogenic Secretary-Treasurer of the hospital at Dauphin, Manitoba. Miss Miller became interested in photography some eight or nine years ago and, within a year or two won first prize, in her class, in the Newspaper National Snapshot Awards. She won the Winnipeg Free Press Amateur Snapshot Contest a few years ago, and her portrait of a small boy called "Anticipation" received an Award of Merit at a Western Canada Salon. In 1946, Miss Miller obtained First Award in the Baby Section of the Little International Salon held at Fargo, N.D., and a year later her study of a dog won the highest award in Class A at the Print Salon of the Western Canada Photographers' Association. In 1947, also, her study "What's the Matter, Chum"?, which is shown here, was awarded a blue ribbon at the exhibition of the North Dakota Photographers' Association held in Fargo.

"What's th' Matter, Chum?"

Miss Miller is very reluctant to say much about herself, but we did learn that she does not depend upon elaborate or high priced equipment. She started with an Eastman F4 post card size; then she obtained a 35 mm. Argus, an F3-5 Eastman, and more recently an F5-6 Graflex, and a 35 mm. Kodak. Miss Miller prefers indoor subjects, particularly children, and finds floodlights much more satisfactory than a flashlight.

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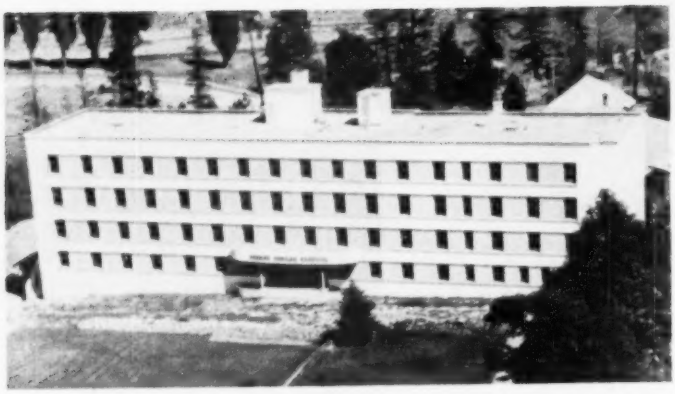
sulting heating engineer or an electrical engineer does not necessarily deprive the hospital of the expert advice of such professionals. These people are usually very sympathetic towards hospitals, especially small ones, and will often give gladly of their time to study a problem within their professional competence. Such disinterested expert advice is worth much to the hospital and it can be obtained without disruption and resentment on the part of the staff and without encouraging a board member to adopt the procedure of persistently interfering with the staff as a sort of enjoyable hobby.

Committees of the Board

The board should, of course, appoint suitable committees for specific tasks. These committees should be essentially study committees, not itinerant groups moving around the hospital trying to manage it piecemeal. They should submit reports to the board as a whole and all decisions for the guidance of the superintendent should be by *resolution of the board recorded duly on the minutes*. I have seen instances where the responsibilities of different committees overlapped and where the chairmen of these committees persisted in offering advice and giving instructions in such a way that there was a clash in the advice and instructions of the different chairmen. The superintendent was left in a disturbed state of mind wondering which person to please and which to offend: this is the inevitable result of such practices. The board of management should always perform its official acts as a united whole in such a way that there can be no mistake as to what is meant and so that differences of opinion between members of the board shall not be visited on the head of the superintendent.

Talking over hospital problems

(Concluded on page 56)



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Vernon Jubilee Hospital Furnished by Voluntary Sponsors

THE opening last fall of the new 115-bed Vernon Jubilee Hospital at Vernon, B.C., marked the culmination of four years of concentrated community effort. Early in 1945, it was decided that the old Vernon Jubilee, which had been in use since 1909, must be replaced, and from that day the board of directors and its associated committees worked tirelessly to make the new hospital a reality. Construction was begun in 1947; now a handsome modern structure stands ready to serve the citizens of Vernon and its surrounding district in the beautiful Okanagan Valley.

The hospital was designed by Frank Gardiner of Gardiner and Thornton and erected at a cost of $560,000, excluding furnishings and equipment. Modern methods and materials were used in its construction and in planning it every consideration was given not only to the comfort of the patient but also to time-and labour-saving devices for the staff. The building is fire-resistant throughout; all exterior walls, floors, beams, columns, stairways, et cetera, are of steel and reinforced concrete with interior partitions of fire-proof tile and gypsum.

The main structure consists of a full basement with four complete storeys above, served by one main stairway, two emergency stairways, a most modern passenger elevator, and a smaller service elevator. The entire ground floor is used for administration and service departments, including business offices and waiting rooms, the main kitchen, x-ray department, physiotherapy department, dining room, and staff rooms. The three upper floors provide accommodation for patients in one-, two-, and four-bed wards and at the south end of each floor there is a solarium for convalescing patients.

Corridor, showing doors leading to solarium.

Because of high costs, in October, 1948, the hospital directors appealed to the public for support in furnishing the wards of the new hospital. The response was very gratifying: almost all the rooms have been furnished by public organizations or by individuals. The walls of the wards are painted in pastel tones with bedsteads and furniture in a deeper hue. Contrast is provided by the chair upholstery which adds a dash of colour and charm. Individual lockers are provided for each patient's clothes and personal belongings, and separate lighting fixtures and reading lamps are attached to each bed. Wards are equipped with night lights, and all lighting is controlled by silent mercury switches. All wards are supplied with hot and cold water, and every room contains a wash basin. Each ward is wired for special hospital radio equipment to allow a patient to listen to his favourite radio programs without disturbing his neighbours.

A special feature in the hospital's construction is the use of "twi-window" glass, a product consisting of two sheets of glass hermetically sealed with a vacuum between. Win-

dows of this type act as insulators against cold and heat, obviating the use of storm sashes. All windows are double hung and reversible, making it possible to clean both sides without exposing the cleaner to any danger. On each window there is a new type of fly screen designed to move up and down like an ordinary blind. This handy device eliminates the need for old-type removable screens.

An increasingly popular door arrangement has been installed. Doors are constructed with two sets of hinges, the first permits the door to open a width of 4 feet allowing for easy passage of beds, and the second allows for a door opening of 2 feet 8 inches for ordinary use. Steel door casings with rounded corners minimize damage to equipment being moved.

The entire floor area of the hospital has been laid with terrazzo flooring and corridors and service departments have ceilings featuring acoustic tile to keep noise at a minimum.

The maternity section contains two case rooms, a nursery with separate cubicles for 35 babies, and a doctors' examination room connected with the nursery by a sliding window so that doctors will not have to enter the babies' room. Special nurseries are provided for sick and premature babies.

K. W. Kinnard, President of the Board of Directors, opens the box buried in the cornerstone of the old Vernon Jubilee in 1908. A copy of the "Vernon News" containing an account of the opening of the new hospital was added to the contents and the box was reburied.

The surgical suite is located on the top floor of the building. It consists of major and minor operating rooms finished in pale green with black trimmed green tile extending half way up the walls. An emergency lighting unit has been installed in case of power failure during an operation, and each operating room has ultraviolet radiation equipment for disinfecting purposes. Another interesting feature is the automatic temperature control in the major operating room. Included in the suite are storage and linen rooms and sterilizing apparatus.

The main kitchen, located on the first floor, is 80 feet long by 17 feet wide. Kitchen equipment is operated by electricity or steam. All cooking is done here, food for the wards being distributed in electrically operated, thermostatically controlled food warmers. The latter are conveyed to the floors by the service elevator which is accessible directly from the kitchen.

In addition to the main structure, a new laundry and boiler building has been erected behind the hospital. It is so engineered that, if at a later date greater bed accommodation should be required, an additional wing, three storeys high, can be built above this section. There are three boilers, one for heating purposes, a second to supply hot water, and the third, which is a high pressure steam boiler, for sterilization and laundry use. Water softening equipment sufficient to serve a 150- to 200-bed hospital has been installed.

In designing and constructing the hospital every consideration was given to fire protection. The materials used in the building itself, a liberal supply of readily available fire extinguishers, and the covering of electrical outlets, are some of the features which will protect the occupants against the hazards of fire.

Superintendent and secretary-treasurer of the hospital is Mr. J. O. Dale, who before his appointement last year was secretary-manager of Lady Minto Hospital at Melfort, Sask.

Left: Two-bed ward.

Below: Four-bed ward.

Appointment to Charles Camsell Hospital

Dr. W. L. Falconer, of Ottawa, an assistant director of Indian Health Services, has been appointed medical director of the Charles Camsell Indian Hospital, Edmonton.

He succeeds Dr. Herbert Meltzer who returned to private practice in January but who will continue to act as consultant on treatment, including surgery.

Hospital Utilization and Costs under Compulsory Prepaid Coverage

Part II

Malcolm G. Taylor, Ph.D.,
Director of Research,
Sask. Health Services Planning Commission, Regina, Sask.

THE second question to consider concerns the costs of this government program which are, obviously, higher than the estimates made before its introduction. It will be recalled by all who followed the Proceedings of the House of Commons Select Committee on Social Security in 1943 and 1944, and the proposals of the Dominion Government in 1945, that the estimate of the annual per capita cost of hospital care at that time was $3.60. It is interesting to note that, at the Dominion-Provincial Conference, it was the Saskatchewan representatives who questioned the adequacy of this estimate.[1] In the revised proposals of 1946, the estimate was increased to $4.60 per capita. In that same year, however, the Dominion Bureau of Statistics Reports indicate that the average per capita cost across Canada was $6.80.

As shown in Table 2, the total cost of the Hospital Services Plan in 1947 was $7,560,762, and in 1948, $8,865,393. In 1947, 49.9 per cent of this amount was contributed from the Provincial Government's general revenues and, in 1948, the percentage of contribution was raised to 57.3. In 1949, it is estimated that the contribution from general revenues will be approximately 42 per cent. The per capita cost in 1947 was $9.69, in 1948 it was $11.42.

In dealing with this problem of total expenditure under the Plan, the factors to be considered may be divided into four groups; those concerned with the costs of doing business, the higher utilization, the payment policy, other programs.

The Costs of Doing Business

This matter requires little or no elaboration for readers of *The Canadian Hospital* but, in the interests of completeness of the analysis, two factors concerning it should be mentioned.

(a) *Increase in the cost of food and supplies.* Unfortunately for budget forecasters, the Saskatchewan Hospital Services Plan was launched just at the time when the effect of the removal of price controls in 1946 was gaining full momentum. Since it was necessary to set the tax rate several months before the inaugural date of the Plan, it was not possible to predict and to take steps to meet the precipitous increase in costs which decontrol brought about.

(b) *Increases in wages and salaries of hospital personnel.* As a result of several factors, including liberalized labour legislation, salaries and wages of hospital personnel in the province of Saskatchewan have been substantially increased. While this has increased hospital budgets, there is no one who would deny that it represents a desirable gain. For too long a time, the personal satisfaction to be gained in service to the sick has been accepted by the public as a rationalization for its continued low wage rates for willing hospital workers.

Higher Utilization

The fact of increasing demand for hospital care, like that of increasing costs, needs no elaboration. As revealed in Figure 1, a sharp increase in the rate of care is evident since 1944, with a continuation of the rate of increase through 1946. This was undoubtedly influenced by the post-war increase of approximately 20 per cent in the number of doctors in 1946 over 1945, as well as by increasing prosperity. There is no reason to assume that there would have been any significant decline in the trend in 1947, even if the Hospital Services Plan had not been introduced that year.

What must be constantly recognized is the cumulative effect of rising costs and rising utilization. Not

Table 2

Expenditures for hospitalization,* sources of revenue, and costs per beneficiary of the Saskatchewan Hospital Services Plan, 1947 and 1948.

Year	Total expenditure	Source of revenue				Cost per beneficiary**
		Provincial general revenue		Hospitalization tax		
		Amount	Per cent	Amount	Per cent	
1947	$7,560,762.64	$3,771,704.03	49.9	$3,789,058.61	50.1	$ 9.69
1948	8,865,393.15	5,076,878.28	57.3	3,788,514.87	42.7	11.42

* Including costs of administration: 1947 — $597,504.95
1948 — 572,114.58

** Covered population (based on 1946 census):
1947 — 780,445 or 93.7 per cent of the population.
1948 — 776,478 or 93.2 per cent of the population.

1. *Submissions and Plenary Conference Proceedings of the Dominion-Provincial Conference, 1945. P. 275; Ottawa, King's Printer, 1946.*

only is the cost of a meal increased, but there are more meals; not only are nurses' salaries higher, but there are more nurses. For example, since 1945 there has been an increase of 60 per cent in the number of nurses employed in Saskatchewan hospitals.

The Payment Policy of the SHSP

Aside from rising costs and higher utilization, perhaps the most important factor accounting for the total expenditure reported by the Hospital Services Plan is the payment policy according to which rates are based on the costs of efficient operation of each hospital. With such a high proportion of each hospital's revenue coming from the Hospitalization Fund, no alternative policy seemed feasible. As C. Rufus Rorem, former director of the Blue Cross Commission, has recently said, "A group payment plan should pay the full costs of the services which are rendered to its subscribers during any period of time. In the long run, these payments should meet the costs of each hospital which contracts to provide services."[2]

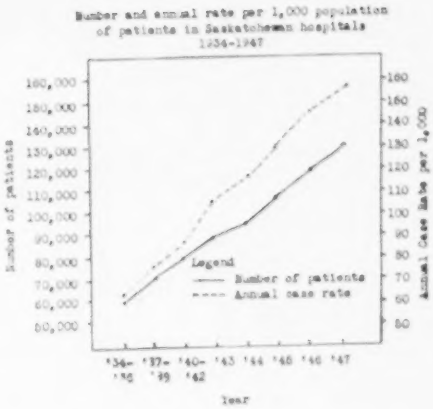
Administrators will appreciate what this means for the hospitals accustomed to collecting "the going rates".

The way in which it affects the Saskatchewan Hospital Services Plan has been well described in the "Obiter Dicta" column of *The Canadian Hospital:* "As the 'going rates' for standard service are usually well below cost and as under a provincial or national scheme the government must, of necessity, pay approximate cost, there would certainly not be any reduction of operational cost under a state plan."[3]

The essential point could scarcely be stated more succinctly. Obviously the expenditures from a central fund which pays the costs of operation will be higher than if the fund pays "going rates" for standard service which are "well below cost" with, presumably, the difference being made up from other sources.

It is the combination of these two facts, the payment of the full costs of operation and the extremely high proportion of the total volume of hospital care provided to Saskatchewan residents for which the Hospital Services Plan is responsible, that makes this figure of total expenditure difficult to compare with those of other prepayment plans.

Fig. I



Expenditure for Other Programs

In the total expenditures of the Plan, there is represented a very substantial sum in lieu of payments for other programs undertaken by the Saskatchewan Government before the inauguration of the Hospital Services Plan. These include:

(a) Since 1906, the province has been operating a program of grants to hospitals based on a per diem payment for each patient. In 1946 the total of such grants amounted to $616,957. If this program had continued at the same per diem rate, the program in 1947 would probably have cost $650,000 and, in 1948, at least $700,000.

(b) Free hospitalization of all cancer patients of the province was inaugurated as a governmeat program in 1944. In 1948, the Hospital Services Plan paid $486,620 for hospitalization of cancer cases.

(c) On January 1, 1945, the provinces undertook a program of free medical, surgical, and hospital care, for all recipients of provincial public assistance. Moreover, the rates paid on behalf of public assistance cases are exactly the same as those paid on behalf of insured beneficiaries. Hospitals and their associations have long advocated these principles. In his testimony before the United States Senate Committee on Education and Labour, in 1945, Dr. Rorem, then Director of the Blue Cross Commission, presented a four-point program, the first point of which was "complete medical care and hospitalization supported by taxation for all public assistance beneficiaries or indigent members of the population."[4] In 1948, the cost to the Saskatchewan Hospital Services Plan of hospitalizing these cases was $760,170.

The total paid from the Hospitalization Fund in 1948, in lieu of payments for programs undertaken by the provincial government before the inauguration of the Hospital Services Plan, amounted to approximately $1,946,740.

Conclusion

The foregoing analysis makes evident the chief factors influencing rates and costs under this hospital care insurance program based on over-all coverage.

Actually, we have only two directly applicable yardsticks by which to measure these rates and costs: the statistical data of voluntary prepayment plans and data

(Concluded on page 60)

2. *"Effect of Rising Hospital Costs on Group Payment Plans", American Journal of Public Health, 39, Jan., 1949, pp. 50-56.*

3. *The Canadian Hospital, 26, March, 1949, pp. 25-26.*

4. *U.S. Senate, Seventy-ninth Cong., 2nd Sess., S. 1606 "National Health Program". Washington: Government Printing Office, 1946, Part 2, pp. 958-959.*

What should the ADMINISTRATOR Know About ENGINEERING?

D. R. Easton, M.D.,
Superintendent,
Royal Alexandra Hospital,
Edmonton, Alberta.

I DO not think the administrator need have a detailed knowledge of engineering any more than the engineer need know much about surgery. He should, however, have sufficient knowledge to be able to discuss problems intelligently with his chief engineer and, in turn, be able to present them clearly to the hospital board when a question of expenditure arises.

Let us imagine we are taking a trip through the hospital, coming in through the back door rather than through the front as we usually do. The first thing that meets our eyes is the *boiler room*. What should an administrator know about the boiler room? He should know what type of boilers is most suitable for hospital service and how much reserve boiler capacity should be installed. The type of boilers to be used must be determined by the fuel available in a particular location (coal, oil, or gas), by the steam pressure to be carried, and to a lesser degree by the chemical composition of the boiler feed water. One-third of the maximum boiler load should be installed for reserve capacity.

The administrator should also know what factors determine the type of fire equipment needed. This again depends entirely on the kind of fuel used and on the type of boilers in operation. Boilers intended to burn coal cannot burn gas, or oil efficiently. How do you determine the efficiency of combustion? Modern steam flometers will accurately record this. To operate boilers efficiently it is essential to have an adequate supply of water, therefore water mains leading to the hospital must be of sufficient size and have proper valve control.

Water for laundry and domestic use must be treated with a softener and the Zeolite process is generally used. It produces a rather chemically unstable soft water which, when heated, causes destruction of hot water tanks by corrosion and pitting. Prevention of this reaction requires counteracting by chemical treatment but, instituting such a process is beyond the realm of the administrator and should be delegated to specialists.

This brings us to a discussion of the laundry. With regard to buying equipment for this department, any large supply house has competent personnel who will review the laundry with the administrator and give him good advice. The chief engineer should be consulted in any purchase of equipment for he will be the one to deal with any mechanical problems which arise.

Elevators

After leaving the laundry, we enter the main building and reach the *elevator*. When new elevators are to be installed the administrator should obtain expert advice. His chief engineer has a vast fund of information, but it is often advisable to have outside consultants as well. The most important features in an elevator are that it should start and stop smoothly and that it should have an even speed when in motion. To achieve this, manually operated elevators should be of the traction type and have at least two-speed acceleration with automatic or micro-levelling at the floors. Another important point which should be remembered is that patients in beds must be transported in the elevator and, frequently, fracture apparatus is attached to the bed and must remain there while the patient is being moved. It is therefore wise, especially on the slower speed service, to have an elevator sufficiently large to hold the longest beds plus fracture equipment. Eight feet is the minimum length with which this can be accomplished.

Stepping out of the elevator, we expect to find corridors and rooms properly heated. *Heating hospitals* is a highly technical problem and, again, expert advice should be obtained when installing or changing any of the heating systems. It is generally considered at the present time that zoned and differential high vacuum systems are superior to the old two-pipe vacuum systems because of their greater flexibility and economy.

Having given consideration to heating in winter, our thoughts now turn to cooling in summer. *Air conditioning* has become so popular in business establishments, theatres, and restaurants, that both patients and doctors are beginning to demand air conditioning in hospitals. The difficulty which arises in hospitals is that no air can be recirculated because of the danger of cross infection. All air must come from outside, be conditioned, and then passed to the rooms. This creates an additional engineering problem and increases the cost. Air conditioning is extremely expensive and expert personnel are required to operate such a system.

From consideration of air-cooling, we turn to *refrigeration*. Ammonia refrigeration is now completely outmoded in hospitals because it involves too much risk in the case of leaks and accidents. Freon refrigeration is the most modern method used in hospitals.

Let us now proceed to the other extreme and study hospital *autoclaves*. The most important feature in autoclaves is the lining, which must be of monel and nickel because these give a hard finish absolutely proof against corrosion and rust. Autoclaves thus lined are more expensive in the first instance, but they are more economical in the long run for they last almost forever.

Electric Power

An important feature which may have passed unnoticed in our trip through the hospital is the *power*

(Concluded on page 58)

From an address presented at the A.H.A. convention in Cleveland, 1949.

An Archival Study—

Early Territorial Hospitals

Victoria Hospital, Regina, was established in 1899 but did not occupy this building until 1901. The hospital later became known as the Regina General.

Lewis H. Thomas,
Acting Provincial Archivist,
Regina, Sask.

THE almost complete displacement of the home by the hospital in the care of the sick is one of the most significant social changes of the last half century. It is difficult for us to realize that the care of the homeless or the indigent sick and the control of epidemics were once the chief considerations in the establishment of hospitals. Not only was much left to private charity, but government contributions assumed hospital services would only be required by needy people or in exceptional cases. However, as the first hospitals appeared in the Northwest Territories, the modern idea that a hospital might provide better nursing care than the home, even for the well-to-do, was gaining ground. There was a special need for extension of hospital service in an area where the population included a large number of single men, and diphtheria and other epidemic diseases were common.

Victoria Hospital, Prince Albert, first opened its doors in this building in 1899. The hospital's name was later changed to the Prince Albert Municipal Hospital.

The earliest hospitals in the Territories were established at Roman Catholic missions. In other centres such as Regina, Saskatoon, and Prince Albert, private nursing homes and home nurses played important roles in the care of the sick, while the North West Mounted Police had hospitals at several of their posts for members of the force. Near the end of the century, the Victorian Order of Nurses helped to install cottage hospitals at a number of points.

By 1898 there were four active hospital associations which had been incorporated by territorial ordinances: Macleod General Hospital

Reprinted from "Saskatchewan History", Vol. 2, No. 2, Spring, 1949. Pictures, courtesy Archives Division, Legislative Library, Regina.

(1887), Medicine Hat General Hospital (1889), Calgary General Hospital (1890), and Galt Hospital, Lethbridge (1894). The constitutions of these hospitals followed a common pattern, a group of local residents were made "a body politic and corporate" with power to hold property and funds for hospital purposes. The affairs of the hospital were managed by a board of directors elected annually by members of the corporation, and membership was based on the payment of an annual subscription. If a grant was received from the Northwest Government, the hospital was required, upon the request of the Lieutenant-Governor-in-Council, to maintain an adequate supply of vaccine for vaccinating poor persons free of charge and others for a fee of not more than seventy-five cents.

The earliest public general hospital in the Northwest Territories was at Medicine Hat. Much care, energy, and enthusiasm went into the planning and organizing of this 40-bed hospital which was completed early in 1890 at a cost of over $20,000. Assistance in meeting construction and equipment costs came from the Dominion and Territorial governments, several companies with interests in the West, a number of generous friends in Eastern Canada, and from the Duke and Duchess of Connaught. In Medicine Hat, as in other localities in the Northwest, the hospital benefited greatly from a variety of fund-raising activities organized by the women of the community. It was partly financed by a system of hospital insurance tickets under which the board of directors agreed to "lodge, board, and give nurse and medical attendance" for a year to anyone who purchased a five-dollar ticket; several hundred took advantage of the scheme during the first year.*

The Medicine Hat General Hospital was the most important institution of its kind in the Territories during the 1890's. In 1895 the Regina *Leader* reported that since the opening of this hospital, Regina patients had been treated for a total of 1,623 days, and it urged larger donations from Regina for the support of the hospital.** In 1896 the Northwest government arranged for incurables to be cared for there and two years later it was reported that "Medicine Hat Hospital is the only one in the Territories employing a resident medical superintendent, and it does a large amount of general work; its clientele being drawn from all parts of the Territories".

The first grants to hospitals by the Northwest government were made in 1889, when $500 was assigned to Medicine Hat General Hospital and $100 to St. Albert Hospital. In 1892 the "Ordinance to Regulate Public Aid to Hospitals" replaced the more or less arbitrary lump sum method of payment by one based on the number of "patient days" provided by each institution. It also empowered the government to appoint an inspector who was to report to the Lieutenant-Governor-in-Council on the management of each institution receiving public aid.

With the formation of departments in the public service of the Northwest government in 1897, the administration of hospital grants was placed under the Department of Agriculture. A section dealing with hospitals in the first report of this Department contains the following comments:

"There is a peculiarly appropriate field for hospital work in the Northwest Territories. A large proportion of our settlers are unmarried men, often living alone and miles removed from the nearest charitably inclined neighbour who could look after them in time of accident or sickness. They are fortunate, indeed, if they can enjoy the luxury of proper care and skilled attendance in a well regulated hospital in such an emergency. I shall not even attempt to describe the dreadful misery which women would in many cases be called upon to endure, to say nothing of loss of life or permanent injury to health, were they not able to utilize the maternity wards of some of our hospitals. Too much stress cannot be laid on the necessity of further developing this feature of our hospital work.

"The country owes a great debt of gratitude to the public spirited people who have, in the past, so generously supported these institutions and who bear the large expense incidental to the efficient management of the same. It can, of course, be readily understood that the Territorial grant, amounting to only a fraction over 13 cents per hospital day or on a basis of 25 cents per day for each free patient treated, will not begin to reimburse hospitals for charitable work done. . . .

"The large influx of settlers during the past year has thrown a great burden upon residents in the vicinity of nearly all Territorial hospitals and from present indications this burden is not likely to decrease from year to year, in fact, quite the reverse may be expected. Indigent immigrants are brought to these insitutions suffering from diseases requiring careful nursing and medical attendance and become a tax upon the voluntary contributors who, as a rule, find the task of providing the necessary funds for keeping their hospitals running under normal conditions quite heavy enough without being called upon to pay for the treatment of absolute outsiders. Steps have been taken by the Dominion authorities to reimburse a few hospitals for the outlay incurred in caring for immigrant patients, but this help should be generally extended."

**Editorial, "Cheap Insurance", Medicine Hat Times, December 19, 1889. See also the annual report of the Board of Directors for 1890, Medicine Hat Times, January 22, 1891.*

***Editorial, "A Deserving Institution", The Leader, December 12, 1895.*

Dr. Hershey Accepts Saskatchewan Post

J. M. Hershey, Ph.D., M.D., D.P.H., has been appointed Assistant Deputy Minister of Public Health and Director of Regional Health Services for Saskatchewan, having resigned his position as Hospital Insurance Commissioner for British Columbia in December.

Prior to the inception of the B.C. Hospital Insurance program, Dr. Hershey had extensive experience in public health administration. He directed health units in Peace River, the Okanagan Valley, and Central Vancouver Island, and also served as assistant health officer for the Province of British Columbia.

In his new positions, Dr. Hershey will assist in the administration of the Department of Public Health and will direct and co-ordinate all public health and medical care activities in the established health regions of Saskatchewan. ●

Food and Its Service

Sponsored by the Canadian Dietetic Association

Cafeteria Service in Hospitals

Muriel J. Westney,
St. Joseph's Hospital
Toronto.

Part II

THE finest equipment, the most elaborate plans, the most complex accounting system, are to no avail without the worker. No institution would carry on many hours without those who serve the food, wash the dishes, clean the floors, and dust and mop.

During the war years we became so used to taking the people who were available that we may have lost sight of the necessary attributes for certain jobs. We gladly reached for any personnel we could get with all the resultant headaches and lowered standards of service. Now in more normal times we can look about us and be more scientific in our choice and training of personnel.

In hospitals, the supervisor should be a qualified dietitian or a well-trained food worker who works under a dietitian. Certainly this person should have authority, some voice in cafeteria policies, and the choice of employees. She should be backed by her associates, have the complete co-operation of the whole dietary staff, and maintain friendly relations with all other departments of the hospital. The supervisor should be popular and the type of person who commands respect because of her integrity, judgment, and knowledge of the work. She must have good health because she will need it. One rash judgment, one emotional outburst, and her rating has gone down in the sight of her employees who look to her as their leader.

Her responsibilities in general are getting the task accomplished, the safety and health of her workers, developing the proper mental attitude in them, and training them for their tasks. The quality of leadership displayed by the supervisor will influence the morale of the workers. They must be interested and feel that they are being treated fairly. The supervisor should not overlook an opportunity to commend good work. She will be rewarded with further improvement.

All employees are not worth the same wage and all should not receive the same. An increase in salary, even if small, will reward the good worker and the news will spread quickly to other workers. This will encourage them because they know that their leader is fair. This method seems to be more effective than promising a girl more money if she does better work.

The employee's satisfaction is also affected by her reactions to the supervisor. Many supervisors do not know how to reprimand—an unpleasant duty which must be performed if the supervisor is to be respected by employees and also to keep up the standards of a good food service. Whenever possible, reprimands should be made in private, so that the employee will not lose face with her associates. In most instances this method is so appreciated that all but the very hardened cases will respond with endeavours to do better, and there will be no resentment.

Teaching

Much of a supervisor's time is spent in teaching, whether it be instructing new employees, or explaining new methods to old employees. Whenever possible a supervisor should personally teach the work to a new member rather than leaving the instruction to another employee. Those who have studied methods of teaching say that the instruction period should be divided into four steps. The first is the *preparation*, which may include a leading question, such as "In your former place of employment did you ever operate a machine like this?" The second part is the *presentation*, an outline of the job which you want done. The third part is the *application*. The worker does the job with the help of the supervisor. This may have to be repeated. The fourth and last part is the *test*. The worker must perform the task herself describing the procedure in her own words to the teacher.

Manuals or work lists are very useful, but they must be kept up to date. With a manual no employee can use the excuse that she did not know her job. A work list should outline the duties during the hours of the day and also daily special tasks such as cleaning.

Choice of Employees

Presuming of course that people are available, let us consider the task of employing suitable cafeteria workers. Many hospitals have their own personnel department. The supervisor sometimes has to take what the employment office sends her. This is unfair. If it is not possible for the cafeteria supervisor to do her own hiring, there should be at least a complete list of qualifications for each job, registered with the employment office.

When a person presents herself at the employment office, there are a few points which must be borne in mind if she is to be considered for cafeteria work. A list of places of employment for the past five years, if possible, should be required. References should be investigated. Cafeteria workers should be clean, neat, and healthy, have good feet, skin free from blemishes, be of medium weight or less, of average height or above, and have good vision, good hearing, and good teeth. Her experience re-

From an address presented at the meeting of the Ontario Conference, C.H.A., November, 1949.

quirements will depend on the job she has to fill.

The workers will fall into four groups, those for preparation, those for counter service, for clearing tables, for dishwashing and porter work. The best age for counter workers seems to be twenty to forty years. The choice of a counter girl is important from the points of view of character and personality. She must like people and want to help them, be cheerful, emotionally stable, and be completely loyal to her employer. She should be quick, intelligent, have a good memory for regular customers' likes and dislikes, and be able to co-operate with, and be popular with her fellow workers. The counter girl should adapt herself readily to change and accept new methods and corrections graciously. The careful choice and training of a counter girl cannot be stressed too much, as the finest equipment and foods can be spoiled by poor serving.

Counter workers, and for that matter all cafeteria workers, should be encouraged at all times to look their very best, with neat hair nets, just enough makeup to be becoming. There should be no objection to nail polish if it is kept in good repair and of not too startling a colour. They should wear clean, neat-fitting, short-sleeved uniforms. A cap or band gives a pleasant appearance and stockings must be worn.

The attitude of the cafeteria workers towards their jobs and their customers is very important. At all times they should look alert. Unnecessary handling of food, stirring of food, toying with utensils, chewing gum, touching hair and face with hands, careless coughing, unnecessary talking, and undue noise should not be allowed. All employees should report complaints and favourable comments to the supervisor. This will help them to take a pride in their work.

In Case of Accident

When there is an accident in the line, employees should help graciously to clear away. This makes the patron feel better. If a worker has made a very embarrassing spill, her supervisor should send someone else to clean up. This allows the girl to regain her composure, and may prevent further accidents.

Accidents can be prevented. The immediate removal of spilled food will prevent someone from slipping. All should be alerted to the danger of accidents, the danger in operating certain equipment, and the hazard of fire. Complete instructions should be given as to what to do in the latter case.

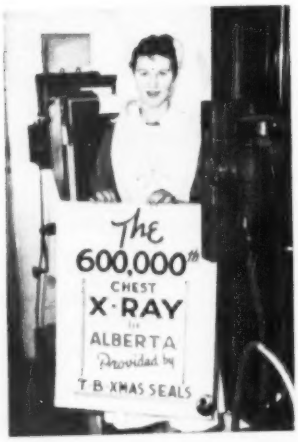
Breakage is one of the major problems in the operation of a cafeteria. It can be cut down by more careful handling, with fewer dishes on each space or tray, by keeping dishes and glasses separate, by using sturdy china that stacks easily, and by having an adequate supply. Sometimes a check on the traffic route of dishes from the time they are served until they are back to be served again will show some hazardous spots which could be eliminated. Making each employer conscious of the actual cost of each piece of china will help them to be more breakage-conscious. The buyer will gladly furnish you with the price of each piece of china. Forcing an employee to pay for broken dishes will only lead to failure to report breakage. A better arrangement is to have them fill out little slips for each breakage. No employee likes too many to pile up beside her name. The perennial dish breaker is too costly to retain. Replace her. Also poorly paid employees will never save dishes for their employer.

Elimination of Noise

One of the criticisms of cafeterias is that they are usually noisy. When the line is in a separate room from the dining tables there is less noise. The workers should be taught to work quietly without unnecessary talk or banging. Doors which bang can be quietened. Composition trays are more quiet than metal ones. A dish room so planned that it can be closed off from the dining room during the height of activity is some help in eliminating noise. Sound proofing of walls and ceilings is ideal.

A difficult task is estimating the number of guests. In hospitals the number of diners falls toward the weekend, and rises again at the beginning of the week. Holidays must be anticipated; bad weather will mean that student nurses will be eating in the hospital. Appetites lag on hot days and increase at the onset of cold weather.

Unlimited advice is available for those planning renovations or building. Large reliable companies are anxious to satisfy needs. Seeing their suggestions on paper and numerous visits to other installations will help you to plan a successful cafeteria by which you can improve relations with your fellow beings by nourishing their bodies and adding to their enjoyment of life.



Fine Achievement in Alberta

Mary Kergan, a Drumheller high school student, received the 600,000th free chest x-ray in Alberta through the Christmas Seal mobile x-ray units owned by the Alberta Tuberculosis Association and operated by the Alberta Department of Health. It is expected that through the success of the 1949 Christmas Seal sale, this year will see further extension of the case finding program through mobile units and hospital x-ray examinations. ●

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Impressions of the

Calgary Convention

A Manitoban Visits the Foothills

By Judge J. M. George,
President,
Manitoba Hospital Association,
Morden, Man.

ONE of the greatest pleasures I have had was the privilege of being a guest at the convention of the Associated Hospitals of Alberta, held in Calgary on November 2, 3, and 4. So impressed was I with the manner in which the convention was conducted, the subjects discussed, and the wealth of information contained in the addresses given, to say nothing of the splendid hospitality of those whose guest I was, that I cannot overcome the temptation to put my impressions into writing. It was the first opportunity that I had had of attending an Alberta convention, and I hope that it may not be the last.

What a setting for such a convention, there in the shadow of the Canadian Rockies, of which we are so proud; in a city typical of the Canadian West and emblematic, in its progress, of the pioneering spirit, the aggressiveness and determination, of of those rugged pioneers who made Western Canada the enviable place it is in which to live!

May we look upon the Rocky Mountains, not only as a gift of nature and of the Hand that guides our destiny, but also a symbol of freedom. They stand as a wonder of creative nature, placed there centuries ago for our use and admiration.

No better setting could we have in which to enact a play based on the fundamental principles of freedom and democracy, with players who (not only in their acting but also in their thinking) are trying to depict and develop that particular way of life which we have so long enjoyed and are doing our utmost to maintain in Canada.

One of the greatest examples of democracy in action may be found in the development of hospital service for the benefit of mankind in the past century. The continuance of the voluntary hospital system will do much toward maintaining democratic principles in other branches of our social and economic life. Therefore, those now engaged in hospital work (both voluntary and otherwise) could find no greater justification for their present efforts to preserve a voluntary system.

The Voluntary System

It was most appropriate that this should be the central theme round which all other discussions revolved at the Calgary convention. It was also very appropriate that this convention was presided over by one of the strongest advocates in Canada of voluntary hospitals, a man who has devoted years of his life, not only to the development of efficiency in hospital service, but also to the preservation of voluntary principles, the President of the association, Dr. A. C. McGugan, Superintendent of the University of Alberta Hospital, better nown to the hospital fraternity as "Angus".

To emphasize the fact that the principles already mentioned are the foundation on which our hospital system must continue to build and to show that leading authorities endorse these principles, I shall quote from Dr. McGugan's presidential address, which informed, advised, and warned of the dangers of the future.

With respect to participation in hospital association activities, he said: "Participation in Provincial and Dominion organizations is a 'must' if hospitals are to survive . . . it is not a matter of philanthropy . . . no one hospital or group of hospitals can paddle their own canoes today and expect to survive. We require the whole flotilla paddling together with one common purpose—adequate hospitalization for a free and independent people."

Dr. McGugan continued: "For the past three or four decades . . . ill-conceived and poorly administered plans for medical and hospital care have sprung up throughout the world. These (have been the work of) short-sighted opportunists who sacrifice the soul of the nation, which is based on initiative and freedom, for expediency. . . . Eventually every problem in hospital economics resolves itself into one problem, namely: Does one advocate individual enterprise or does one advocate totalitarianism? . . . It resolves itself into a question of political philosophy."

Some of the problems that he said we had to face were: ". . . financing, government encroachment in the field of the voluntary hospital, and the problem of securing and training an adequate supply of nurses."

Warning again of the dangers of state control of hospitals he said: "Hospitals have been calling upon governments for increased help. We, as citizens of a democracy, are slow to realize that each time we delegate a responsibility to a government we sacrifice a corresponding privilege and take one further step towards state control and totalitarianism."

What a fine philosophy on which to base our thoughts and actions in the future development of hospital service.

Then there was that other staunch supporter of the voluntary hospital, Father Hector Bertrand, President of the Catholic Hospital Council of Canada, a man well-known and respected in the hospital field. A hospital convention or any gathering of hospital workers, would not be complete without Father Bertrand. His sincerity, his ever ready wit, and his eloquence, stir one to greater effort and make one feel that his work on behalf of the hospitals is well worth while. He gave an interesting history of the development of the voluntary hospital system in Canada and elsewhere, stressing that any future development must be built on the foundation laid by the volunteer workers, who are best able to guide the future destiny of hospital service. They are best fitted to give advice to those who in the development of new hospitals need guidance. He emphasized his remarks by saying: "Leaders of a country should not always give the people what they desire but rather

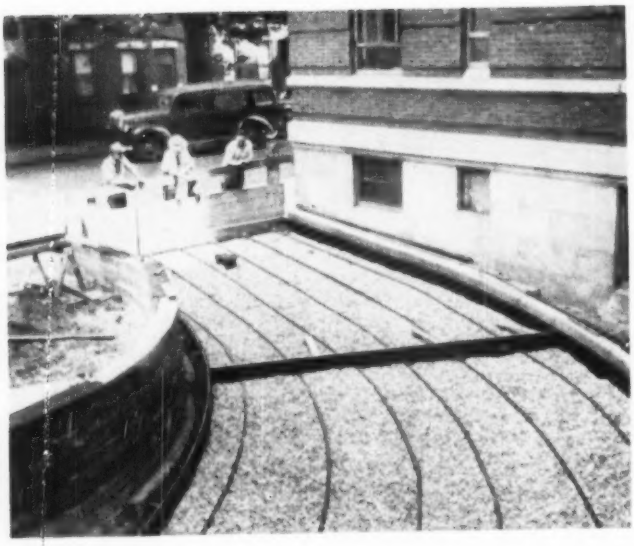
what is for their good, just as a father would not grant his child a favour which would be harmful to him."

No provincial convention is complete without a message from our Canadian Hospital Council, which has done so much to assist provincial organizations and, through them, individual hospitals across Canada. For the first time, to my knowledge, Dr. Harvey Agnew, the guiding hand and the veteran in that work, was not with us. "Harvey" we did miss you! The Council, however, was ably represented by our new president, Mr. Fraser Armstrong, of Kingston, Ont. His address on "The Canadian Hospital Council—Its Contributions to the Welfare of Canadian Hospitals" made us realize more fully just how important that organization is to the welfare of our hospitals. One of the great values of voluntary effort is that it draws into its fold of workers the best type of Canadian citizen; Mr. Armstrong, like others I have mentioned, is no exception. His friendly smile and genial manner win his way into your heart the moment you meet him and that, coupled with his years of experience, leaves no doubt in our minds that we have chosen a president who will guide the Council wisely and well during his term of office. He also emphasized the importance of having those of experience guide the novices in hospital work, when he said that there was a great need, not only to guide, but to warn against dangers that lay ahead.

There were about 285 delegates in attendance, including trustees, Women's Auxiliaries, Administrators, and other hospital personnel. What an inspiration that was, not only to the officers in charge but to all present! Not to be overlooked was the fact that many members of the provincial Department of Health, including Dr. W. W. Cross, were there both as participants and listeners. This was most encouraging to me, and proved that in Alberta the government and the hospital association are working together in an endeavour to find the best method of giving the most efficient hospital service in the least expensive way. It is also evidence of the fact that the government is not unappreciative of the value of the advice and guidance in hospital matters that can be given by those who have had actual experience in that field.

One cannot overlook the ladies and the work that they are doing in support of hospitals. In recent years, particularly in Western Canada, many hospitals might have been forced to close down had it not been for the support given by the ladies. Women's auxiliaries have proven themselves to be a necessary part of the hospital organization. So important has their work become that they have found it to their advantage to form provincial organizations in many of the provinces, Alebtra being one of the most recently organized. I had the privilege of being invited to one of their meetings and of saying a few words to them. Had I been able to remain for any length of time, I would undoubtedly have heard the same kind of reports that are being given at similar meetings, reports that tell of their untiring efforts in the service of hospitals, and of the many means they are taking of raising money and providing services.

As the convention came to a close with the passing of important resolutions, I could not resist the temptation to turn my eyes westward. There were the Rockies, grand and glorious in the light of the setting sun, still standing on guard as for ages past, with the sun going down between two peaks as if choosing a place from which it might linger to throw its light on the closing ceremonies of the convention. The sun and the Rockies, together saluting those who were upholding the true principles of democracy, added a fitting climax to a work well done.



Snow-Melting System in Ambulance Drive

To keep the ambulance drive of a new addition at South Side Hospital, Pittsburgh, free of snow and ice in winter, wrought iron pipe has been imbedded in the reinforced concrete surface. The pipe will supply enough warmth to keep the section clear under any winter condition. The driveway curves in a 90-degree arc and slopes downward into a sheltered area at basement level.

M.I.T. Course in Food Technology

The Massachusetts Institute of Technology has announced a three weeks' special course in food technology to be given under the direction of Dr. Bernard E. Proctor, professor of food technology at the Institute. The course is being held from June 12 to 30, and will emphasize recent developments of food manufacture and control. Tuition is $100.

Letters of application, giving applicant's experience and background may be sent to Professor Gale, Room 3-107, M.I.T., Cambridge 39.

Notes on Federal Grants

Construction

The federal government has made a grant of $143,000 to the Guelph General Hospital, Guelph, Ont. The present hospital is to be renovated and converted into a 52-bed hospital for the treatment of chronically-ill patients. A new building is being erected for the active treatment of medical, surgical and obstetrical cases. It will have space for 146 beds and 39 bassinets.

A grant of more than $69,300 has been authorized for the new General Hospital at Port Colborne, Ont. To be completed this spring, it will have 62 beds and a 22-bassinet nursery.

The McKellar General Hospital, Fort William, Ont., and Victoria Hospital, London, Ont., have each been granted assistance in enlarging their present accommodation. At Fort William, a quonset hut has been set up to provide accommodation for 26 patients. The federal government is matching the provincial grant of $15,844 toward the cost of this work. A second grant of $3,750 has been authorized for Victoria Hospital, to help meet costs of converting obsolete washrooms, et cetera, into space for additional beds.

A grant of $58,000 was awarded to the new 52-bed Humber Memorial Hospital at Weston, Ont., to help meet building costs.

The new hospital being built at Harrington Harbour, Quebec, has been awarded federal grants totalling more than $23,600 as an aid in its construction costs. This hospital, operated by the International Grenfell Association, will have 15 beds for general treatment, a nursery with eight bassinets, four beds in a sparate section for tuberculosis patients, plus service departments including a dental suite.

The federal government has made a grant of more than $136,900 to the new West Coast Sanatorium being built by the Newfoundland Department of Health at Cornerbrook, Nfld., to provide hospital facilities for tuberculosis cases on the west coast of that province. The sanatorium will have 220 beds for tuberculosis care and seven beds for other types of illness. Fifty beds are being reserved for war veterans, and the Department of Veterans Affairs will assist with the cost of building that section.

In Charlottetown, P.E.I., alterations and additions are being made to the Prince Edward Island Hospital Annex to provide five more beds and 49 bassinets. The federal grant toward the cost of this work is $20,000.

Federal funds totalling more than $3,300 have been granted to the Bayview Memorial Red Cross Hospital at Advocate, N.S., where alterations to the present building will provide space for an additional four beds.

At Hazelton, B.C., the Wrinch Memorial Hospital, operated by the United Church of Canada, is building an addition to the staff residence. This will release space in the hospital for the accommodation of eight more beds for patients and qualifies the hospital for $8,000 in federal grants.

The new Gainsborough Union Hospital at Gainsborough, Sask., replaces an obsolete five-bed nursing home. It will have 10 beds and related facilities for medical, surgical and obstetrical care. The federal grant is $10,000. At the Grey Nuns' Hospital, Regina, an addition to and alterations in the present building will give space for 10 more beds and 58 bassinets as well as a number of other hospital services. The federal contribution to construction is more than $29,300.

A new medical nursing unit is to be established at Wawanesa, Man. It will have six beds, a case room, and living quarters for the staff. The federal grant is more than $7,000.

Mental Health

More than $17,500 have been allotted to buy operating room and other special equipment for the Crease Clinic of Psychological Medicine, Essondale, B.C. The operating room at the new clinic is being equipped for both general and neurosurgery, and will be used for all surgery required by patients at both the clinic and the Essondale provincial mental hospital. A grant has also been approved for purchase of recreational therapy equipment to aid in the development of an activities program for the patients at the Crease Clinic.

Federal funds will also help to buy teaching aids for the courses in anatomy and physiology at the training school for psychiatric nurses at Saanich, B.C., and a Vancouver doctor has been awarded a federal bursary for a year's special course in mental hygiene and psychiatry at the University of Toronto.

The federal government has approved grants of more than $24,000 to buy additional equipment for and to increase the staff of the hospital for Mental and Nervous Diseases, St. John's, Nfld. More than $12,000 have been allotted to buy x-ray equipment for the out-patient department of the hospital. About $5,000 will be used to obtain special operating room equipment to introduce a leucotomy program. Smaller amounts have been provided to buy additional instruments and supplies for the full time dental clinic at the hospital and to obtain photographic equipment, charts, books, and films, to be used in instructing the staff and nurses-in-training. Funds will also be used to provide salaries for two more graduate nurses and two more ward aides for the hospital staff.

Personnel

To aid in training more personnel in public health, federal bursaries have been approved for two persons in New Brunswick. One bursary provides for a year's training in public health at Dalhousie University, Halifax, and the other is for a short course in hospital planning in Cincinatti, Ohio. Grants have also been approved for New Brunswick, to employ additional personnel to prepare and distribute statistical data needed by public health doctors and nurses in the field and to maintain more adequate records within the provincial health department.

Funds have been allotted to Saskatchewan for the training of more persons in public health and to increase the staff of provincial health services. More than $3,000 have been granted for training personnel as combined laboratory and x-ray technicians for service in smaller hospitals throughout the province. A federal bursary has been provided for a year's course in physiotherapy at the University of Iowa. Federal funds have also been set aside to pay the salary of a statistical clerk for Health Region 13, North Battleford, who will prepare data on health problems for the use of district medical officers and public health nurses.

The federal government has allotted $12,000 for the purchase of additional equipment to improve teaching facilities in schools of nursing and the school for nursing aides in Alberta. Funds have also been provided to help the University of Alberta finance a short course in hospital administration for matrons from small hospitals, as well as to provide five bursaries for public health workers. Total cost of these projects is about $15,000.

Federal funds will be used to add a nutritionist to the Nova Scotia health staff. She will specialize in nutritional problems throughout the province. Federal grants will also be used to meet the part-time salary of a bronchoscopist for the Point Edward Hospital, N.S., and to buy the highly technical instruments needed to establish this new service.

Public Health

Federal funds have been granted to New Brunswick's public health services to buy equipment for new public health nursing offices opened this year, and to develop a public health reference library for the staff of the provincial Department of Health and Social Services. Funds have also been allotted to provide equipment needed for a blood bank service at hospitals in Woodstock, Tracadie, Fredericton, Bathurst (J. H. Dunn), Chatham (Hôtel Dieu), Saint John (General), Campbellton (Hôtel Dieu), Sackville, Sussex, Bathurst (Hôtel Dieu), St. Stephen, Lameque, and Newcastle.

Federal grants to pay for medical and technical equipment have been awarded to the Sandy Beach Nursing Home in northern Saskatchewan.

Federal funds have been approved for the purchase of equipment to be used in three well-baby clinics in Nova Scotia. The clinics are at New Road, Woodside, and Bear River.

Tuberculosis

Federal grants have been made to six more hospitals, in New Brunswick, for x-ray equipment. The hospitals are: Saint John General, the Moncton City, and the Hôtel Dieu hospitals in Chatham, Edmunston, Bathurst and Tracadie. Equipment has already been purchased for St. Joseph's Hospital, Saint John; Hôtel Dieu, Campbellton; Chipman Memorial, St. Stephen; and Fisher Memorial, Woodstock. Total cost of the equipment for the six hospitals is more than $54,000.

The new chest clinic at the Halifax Tuberculosis Hospital will receive more than $4,000 for an extension of facilities. As well as providing tuberculosis control facilities for the city of Halifax, this is also a teaching clinic for medical students from Dalhousie University.

Cancer Fellowships Awarded

Dr. William T. Dingle, Winnipeg General Hospital, and Dr. Thomas G. Stoddart, Ottawa Civic Hospital, have been selected as British Empire Cancer Campaign Exchange Fellows for 1950-51. They are both radiotherapists and during their fellowships will study methods of radiotherapy in Great Britain.

These fellowships were first established in 1949 and each year two are available to Canadians on exchange basis with the official cancer agency in England. The fellowships afford opportunities for advanced training and experience in Great Britain in specialized fields of investigation pertaining to the problem of cancer. They are offered to Canadians interested in the clinical and allied sciences or in fundamental research.

The surgeon is now primarily a physiologist and only secondarily a technician.—*Lord Moynihan*

Traffic Signal System for Paraplegics

D. R. Cameron, a paraplegic veteran of World War 1, is shown inaugurating a traffic signal system which is designed to allow paraplegics and pedestrians to obtain "right of way" by depressing a push button before crossing the intersection. The system was installed at the intersection of No. 37 highway and Metropolitan Blvd., Ste. Anne de Bellevue, Que.

Shown with Mr. Cameron are, from left to right: J. B. A. Mickie, manager of Ste. Anne's Hospital; Dr. J. P. Laplante, medical superintendent of the hospital; Miss N. Kennedy-Reid, matron; E. Vincent, orderly; and Ernest Gohier, chief engineer of the Provincial Department of Roads.

With the Hospitals in Britain

By "Londoner"

C. E. A. Bedwell

Dear Mr. Editor:

In the numerous discussions about the national health service, little attention has been paid to the contribution of dentistry. It is commonly regarded as a truism that the care of teeth is one of the prime factors in a healthy life. In practice, the development of the school dental service is a recognition of this fact. This section has, indirectly, been seriously affected by the national health service. In carrying out the provisions of the Act, great difficulty was found in determining the remuneration appropriate for medical and dental services. It was particularly difficult to find any satisfactory basis for paying dentists, and the result was that dentists were enabled to earn incomes far beyond their previous reach. In Hull, for example, one dentist was paid £7,452 between April and November. In consequence the school dental service suffered seriously, for the comparatively small salaries it could pay failed to retain some of the men engaged in it.

Accordingly a Working Party was appointed by the Minister of Health and the Secretary of State for Scotland to ascertain the average chair-side time taken to complete each type of treatment by the general dental practitioner (1) under the national health service and (2) in private practice. Items such as orthodontic treatment, for which it is impracticable to establish an average time, were excluded. Dentists were chosen at random and each was asked to supply a "log" of his operations for one whole week.

The published result of this inquiry gives a most favourable impression of the clear and fair way in which the figures were collected and the deductions drawn from them. The Working Party came to the conclusion that "most dentists are working longer hours than is comfortable, or than would be good for them if continued for too long a period, and many of them are working more quickly than they would normally." Although the establishment of the national health service undoubtedly created a greater demand for the services of dentists, it had been becoming increasingly apparent for some time that the number of dentists was inadequate to meet the national requirements. The Working Party go on to say that "as a body, they (the dentists) have been trying to cope with the difficult problem of keeping pace with the demand without loss of efficiency and, as a body, the Working Party thinks they should have received more gratitude and less adverse criticism than has actually been the case". There seems to be no immediate remedy for this state of affairs as it will probably be many years before there is any appreciable increase in the number of dentists. The principal means of relief will be through the employment of technically qualified chair-side assistants and better organization of the work. It was the men who had already recognized this fact who were at once in a position to increase their output (or should it be "input"?) and so substantially increase their financial reward. With reference to this, the Working Party adds: "Human beings are rarely actuated by a single motive. The Working Party recognizes and admits that certain dentists are working too long, too quickly, and with an eye fixed too closely on the monetary reward for their labours; some of them to such an extent as to create grave doubts as to whether they can work efficiently."

Dentistry under the Health Service

It would be tedious and beyond the scope of a letter to go into the details of the figures presented in the report, though it may be pointed out that they are applicable to all dentists wherever they may be working. They include clinical examination and report, normal scaling and gum treatment, fillings, conservation of deciduous teeth, roof treatment, extractions with local anaesthetic, extractions with general anaesthetic, dentures-non-metallic, relining of dentures, repairs to non-metallic dentures and orthodontic appliances, radiological examinations, treatment of sensitive cementum, arrest of bleeding, domiciliary visits, and items not included under other headings. The fact that only 3¼ minutes elapse between patients shows that there is not much time lost in getting on with the work. The report now provides an exact basis upon which to determine the rate of remuneration. The prospects may do something to improve recruiting for the profession, though it must be a long time before it can have practical effect.

The Heart of the Hospital

The hospital administrator is the heart and nerve centre of the modern hospital. From the gleaming antiseptic operating room to the black-dusted boilers that send heat through the miles of hospital pipes, the administrator knows what goes on and why. It is his—or her—job to see that each department functions efficiently and that all work together as a unit, to bring the sick and the hurt back to health.—*"At the Helm of the Hospital", A.C.H.A.*

With the Auxiliaries

Essay Contest to Stimulate Interest in Nursing

In an effort to create added interest in nursing among young girls, the Manitoba Women's Hospital Aids Association is sponsoring an essay contest among students of Grade XI and Grade XII on the subject, "Why I Wish to Become a Nurse". Essays are not to exceed 1,500 words and all entries must be in the hands of the secretary of the association not later than February 28th. Three cash prizes are being offered: 1st, $75.00; 2nd, $50.00; 3rd, $25.00.

* * * *

Successful Bazaar in Chesley, Ont.

A highly successful bazaar was held before Christmas by the Women's Hospital Aid of the Chesley and District Memorial Hospital. Over 700 people attended and the proceeds amounted to more than $1,300. Booths were gaily decked in the Hospital Aids' colours, blue and white, and featured such items as home cooking, candy, toys, dolls, dairy products, bouquets, Christmas gifts, used clothing, and white elephants. So that mothers might shop at their leisure, three teen-agers loked after small children and movies were held to entertain the older ones.

* * * *

Annual Meeting of Payzant Aids

Reports given at the annual meeting of the auxiliary of Payzant Memorial Hospital, Windsor, Nova Scotia, showed that 1949 had been an active and successful year. The treasurer reported receipts of $4,661.43 and expenditures of $2,024.32, of which $1,501.97 was spent for hospital furnishings and equipment. Among other projects, the auxiliary supplied screens and rods for the women's ward, provided treats for the patients and staff at Christmas, gave prizes and held a reception for the nurses graduating, and donated $100 to the hospital elevator fund. At the meeting, the members voted $600 towards the purchase of an operating room light.

Mrs. Harold Baird was again elected president, and Mrs. R. C. Mills will be the secretary for the coming year.

50th Anniversary Celebration

The year 1949 marked the 50th anniversary of the formation of the Women's Hospital Aid of the Royal Alexandra Hospital in Edmonton, Alberta. The occasion was marked by a Golden Anniversary Tea at which Mrs. W. J. Melrose, a veteran member of the auxiliary, reviewed the organization's half century of service.

Pictured from left to right are: Mrs. John Oliver, president; Mrs. W. J. Melrose; Dr. A. F. Anderson, retired superintendent of the hospital; Miss M. S. Fraser; and Mrs. P. A. Rooney, convener.

Priscilla Campbell Awarded Life Membership in the A.H.A.

Miss Priscilla Campbell, administrator of the Public General Hospital, Chatham, Ontario, has been granted life membership in the American Hospital Association—an honour awarded to only a very few who have given many years of service to the hospital field. In making this announcement, Mr. George Bugbee, Executive Secretary of the A.H.A., indicated that "this token of appreciation" was conferred in recognition of Miss Campbell's loyalty, discriminating assistance, and continuous efforts on behalf of that continent-wide Association over a long period.

Miss Campbell is also a member of the American College of Hospital Administrators; a member of the Board of Directors and a past-president of the Ontario Hospital Association; and serves on the Editorial Board of *The Canadian Hospital*.

Travelling Mental Health Clinic Set Up by Quebec Hospital

A travelling mental health clinic—the first in the Province of Quebec—has been established in Sherbrooke by the Verdun Protestant Hospital with the aid of Dominion-Provincial health grants.

Dr. A. Silver, psychiatrist in charge of the clinic and Herbert Dorken, staff psychologist at Verdun, travel to Sherbooke for the one-day clinic every two weeks. A morning session is held in the Child Welfare Clinic and in the afternoon the mental health interviews are given in the out-patient department of the Sherbrooke Hospital. Patients must be referred to the clinic by the family physician who later carries out recommended treatment.

◂ Health Care Plans ▸

D. W. Ogilvie Named Director of Ontario Blue Cross Plan

Mr. A. J. Swanson, Chairman, Board of Administration, Ontario Blue Cross Plan for Hospital Care, has announced the appointment of Mr. D. W. Ogilvie as Director of the Plan. Mr. Ogilvie has been Deputy Director since July, 1947, when he became associated with the organization.

David W. Ogilvie

During this two and a half year period the Ontario Plan has passed two more mile-stones—enrolment of its one millionth participant and the hospitalization of its 500,00th patient. Since the "millionth" was enrolled, in February, 1948, enrolment growth has continued and at the present time 1,300,000 (1 in 3) residents of Ontario are protected by the Plan. During this period, also, non-group enrolment has been introduced for the benefit of those not employed where group enrolment is available.

Blue Cross in Ontario can look forward to continued prosperity under the direction of Mr. Ogilvie.

* * * *

First Aid Chart

As a ready guide in case of household accidents, the Ontario Plan for Hospital Care is offering a first aid chart designed for posting on the medicine cabinet door. These charts (size 9¼" x 12½") contain information on such subjects as bites, bruises, burns and jects as bites, bruises, frostbite, poisoning, and scrapes, to mention but a few. Subscribers may obtain these convenient and useful charts through their group leader.

Manitoba Blue Cross Opens Three New Areas

The fact that Blue Cross is widely accepted by the public and has found favour with local organizations has been well demonstrated in Manitoba. The Chamber of Commerce, the Women's Institute, and the Rotary Club recently sponsored successful Blue Cross campaigns in Elgin, Amaranth, and Minnedosa, respectively. Campaigns are now under way at Winkler and Homewood.

* * * *

Increasing Service

Almost a quarter of a billion dollars, representing more than 85 per cent of income, was paid to hospitals by Blue Cross during the first nine months of 1949, the Blue Cross Commission of the American Hospital Association reported.

From a total income of $283,950,678, the 90 plans of the United States and Canada paid $241,712,040 for members' care and used only $25,130,363 (8.85 per cent) for operating expenses.

There was an enrolment of more than 35,000,000 persons in the United States and Canada on September 30, 1949. More than 22 per cent of the total population of the 47 states and District of Columbia served by Blue Cross have enrolled, while the combined population of the seven Canadian provinces who have this service show a 23 per cent enrolment.

Aureomycin Placed Under Food and Drug Regulations

According to a recent announcement of the Department of Health and Welfare, the new antibiotic, aureomycin, has been added to the list of items which may be sold to the public only on prescription. Clinical tests of it are still being carried out, with the indications being that it will prove useful in the treatment of some infectious developing from organisms that are resistant to penicillin and streptomycin.

Under the new regulations aureomycin manufactured in or imported into Canada must meet specific standards as to moisture content, the strength of the preparation, and freedom from certain other substances. The potency of the drug must be shown on the labels of every package.

Coming Conventions

March 1-3—American Protestant Hospital Association, Congress Hotel, Chicago.

March 10-11—A.H.A. Institute on Hospital Purchasing, Buccaneer Hotel, Galveston, Texas.

March 30-31—A.H.A. Institute on Hospital Personnel Relations, Hotel Statler, Boston.

May 17-20—Canadian Tuberculosis Association, Annual Meeting, Hotel Vancouver, Vancouver.

June 19-23—Canadian Medical Association, Nova Scotian Hotel, Halifax.

June 26-28—Canadian Society of Laboratory Technologists, Admiral Beatty Hotel, Saint John, N.B.

June 26-30—Canadian Nurses' Association, Biennial Meeting, University of British Columbia, Vancouver.

Sept. 18-21—American Hospital Association, Atlantic City.

Oct. 11-12—Saskatchewan Hospital Association, Saskatoon.

Oct. 16-21—Western Canada Institute for Administrators and Trustees, Fort Garry Hotel, Winnipeg.

Oct. 23-Nov. 3—A.H.A. Personnel Management Institute, Cornell University, Ithaca, N.Y.

Oct. 24-27—British Columbia Hospitals' Association, Vancouver Hotel, Vancouver.

Oct. 30-Nov. 1—Ontario Hospital Association, Royal York Hotel, Toronto.

Nov. 1-2—Ontario Conference of the Catholic Hospital Association, Toronto.

◂ Library Service ▸

RECENT additions to the library of the Canadian Hospital Council are listed below. These publications are, of course, also available on loan for the usual period of three weeks.

READINGS — Hospitals and Radiologists, Pathologists, Anesthesiologists. Pp. 72. 1949. A collection of articles from hospital and medical journals concerning the practice of medicine by hospitals and methods of reimbursement of specialists. American Hospital Association, Chicago, Ill.

CARDIAC CLINIC, Standard Requirements for. Pp. 15. 1948 revision. New York Heart Association, Inc., New York 29, N.Y.

THE INFANT FORMULA ROOM, Procedures and Layout for. Pp. 52. 1949. American Hospital Association, Chicago, Ill.

PRENATAL CARE (Children's Bureau Publication). Pp. 76. 1949. Federal Security Agency, Washington, D.C.

MEDICAL DIAGNOSTIC SERVICES for Small Communities. Pp. 47. 1949. The W. K. Kellogg Foundation, Battle Creek, Mich.

HOSPITAL LAUNDRY, Manual of Operation. Pp. 167. 1949. American Hospital Association, Chicago, Ill.

PLANNING THE HOSPITAL LAUNDRY. Pp. 31. 1949. Canadian Hoffman Machinery Corporation, Toronto, Ont.

RECOMMENDED SAFE PRACTICE for Hospital Operating Rooms. (Adopted by National Fire Protection Association and National Board of Fire Underwriters). Pp. 31. 1949. National Fire Protection Association, Boston 10, Mass.

INSURANCE FOR HOSPITALS, Report and Recommendations of the Committee on. Pp. 8. 1949. American Hospital Association, Chicago, Ill.

SOUND PERSONNEL PRACTICES in hospitals, the Development of. (Section 1, of "Hospital Personnel Administration"). Pp. 77. 1948. American Hospital Association, Chicago, Ill.

CONFERENCE TECHNIQUES Section 2 of "Hospital Personnel Administration"). Pp. 142. 1949. American Hospital Association, Chicago, Ill.

HOSPITAL RECORDS ADMINISTRATION—Manual of Procedures. Pp. 72. 1949. American Hospital Association, Chicago, Ill.

THE PATIENT AS A PERSON (A Study of the Social Aspects of Illness). Pp. 423. Third Printing, 1946. G. Canby Robinson, M.D. Commonwealth Fund, New York 22, N.Y.

A PATTERN FOR HOSPITAL CARE. Pp. 368. 1949. Eli Ginsberg, Ph.D. Oxford University Press, Toronto, Ont.

CONDUCTING AN INSTITUTE PROGRAM —A Report of the Council on Education, American Hospital Association. Pp. 31. 1949. Suggestions on how to administer a statewide institute program based on the experiences of the Ohio Hospital Association. American Hospital Association, Chicago, Ill.

THE CARE OF THE AGED, Modern Methods in. Pp. 14. Reprinted by the Department of Health for Ontario. 1949. Report of an address by L. Z. Cozin, F.R.C.S., geriatrician in England. Department of Health for Ontario, Toronto, Ont.

PUBLIC HEALTH NURSING, Techniques of Supervision in . Pp. 466. 1949. Ruth B. Freeman, R.N. W. B. Saunders Company, Philadelphia and London.

COMMUNICABLE DISEASE NURSING. Pp. 776. Second Edition, 1949. Theresa I. Lynch, R.N. The C. V. Mosby Company, St. Louis, Mo.

OPERATING ROOM TECHNIQUE. Pp. 765 (with 668 illustrations). Second Edition, 1949. Edythe Louise Alexander, R.N. The C. V. Mosby Company, St. Louis, Mo.

Metropolitan Hospital Trustee Board Reorganized

The board of governors of the municipally owned Metropolitan Hospital at Windsor, Ont., has been reorganized following the Royal Commission Inquiry into the administration of the hospital conducted some months ago. Although the action of the city council was based on the report of the Commissioner, Judge Eric W. Cross, the recommendations were not followed in all details.

With the mayor and two controllers dissenting, the council approved a board which will have 11 to 13 members. There will be four members appointed by the city council, two of whom shall be members of the council; the mayor is barred from sitting on the board. One member is to be appointed by the Metropolitan Aid Society, one by the medical staff of the hospital, and one by the Essex County Council. Two additional members are to be named by the foregoing with a provision that if a Metropolitan Trust Association (a body to stimulate voluntary support) is set up, it may have no less than two and no more than four members.

The City Solicitor, Mr. Lorne R. Cummings, has been authorized to make application for the introduction of a private bill to amend the City of Windsor Act in order to ratify the new board.

A movement to have the hospital placed directly under the city council was rejected.

Housekeeping Short Course

Applications are now being accepted for an eight-week short course in hospital housekeeping, sponsored by the American Hospital Association. The course will be given at Michigan State College during April and May. It has been planned both as a refresher course for housekeepers and as a training course for personnel interested in learning the fundamentals of hospital housekeeping.

Application should be made to the Director of Short Courses, School of Agriculture, Michigan State College, Lansing, Mich.

Examination of Candidates For Membership in C.S.R.T.

THE Canadian Society of Radiological Technicians has recently published revised rules and regulations for examination of candidates for membership in the C.S.R.T., compiled by the Board of Directors and Board of Examiners (under the chairmanship of Dr. E. A. Petrie). The aim is, primarily, to acquaint candidates with the essentials demanded by the C.S.R.T. for examination and registration of x-ray technicians. The following is a brief summary of the rules and regulations.*

Qualifications of Candidates

Applicant shall have junior matriculation or its equivalent, plus two years training under a qualified radiologist. After January 1, 1953, all candidates shall have had at least one year of high school physics and must have had two years training under a radiologist certified by the Royal College of Physicians and Surgeons or who is a diplomate of the American Board of Radiology. Two years' training is essential but, at the discretion of the Examining Board, the applicant may be allowed to write the examination 60 days before the full training has been completed.

Applicant shall not be less than 21 years of age before certificate is granted but may be allowed to write the examinations before the age of 21 has been reached.

It is recommended that all candidates shall join the local provincial society as student technicians when starting training.

How to Apply

Application forms may be obtained from the local secretaries of provincial societies and, when filled in by the candidate, complete form with fee and photograph must be submitted to the local secretary. The latter will forward it to the Secretary or the Chairman of the Examining Board and, in doubtful cases, will indicate what action the local society would recommend. Applications must reach the Secretary or the Chairman of the Examining Board at least one month before date of examination.

Concerning Examinations

Examinations shall start on the first Friday of May and the first Friday of November in each year. Papers in anatomy, darkroom technique and physics shall be written on the first day, radiography and therapy on the second. Practical work must be in the hands of the local secretary not later than one week from the first day of writing papers. Secretaries of member-societies shall arrange for the required supervision and place or places of examination.

Written examinations shall be divided into the following five subjects: anatomy, processing room technique, physics and apparatus, radiographic technique and therapy. The practical examination shall consist of a number of demonstration films which will be graded on all aspects of radiographic technique involved.

Written examinations shall have candidate's code number only clearly written on each page: films also must be marked with date and code number only.

Required Standards

To be successful in the examination, candidates must obtain an average of 60 per cent in all subjects, and a minimum of 50 per cent on each and every subject. Failure in more than two subjects will necessitate re-examination in all subjects. A student failing the whole examination may rewrite only at the second subsequent examination. A student failing in one or two subjects may rewrite these subjects at the next examination. All rewrites must be done within one year, otherwise the entire set must be rewritten.

Examination Fees

Examination fee of $5.00 shall accompany application form and will not be refunded if candidate fails to present himself on date and at place specified. The fee for rewrite on one or two subjects shall be $3.00 and shall accompany application form to rewrite.

The Board of Examiners

The Board of Examiners shall consist of two radiologists and one technician. At least one of the radiologists shall be bilingual. The technician shall be a regular member of the C.S.R.T. Appointments to the Board of Examiners shall be made by the Board of Directors of the C.S.R.T. from nominations received in such manner as the Board of Directors shall from time to time direct. All appointees to the Board of Examiners shall serve for a term of three years or until their successors shall be appointed. The Chairman of the Board of Examiners shall appoint a Secretary to the board who is resident or working in his district.

It shall be the duty of the Examining Board to prescribe examinations in anatomy, physics and apparatus, general radiography, darkroom technique, therapy, and practical radiography. The Chairman of the Examining Board shall arrange for the French translation and printing of papers. The Examining Board shall use care and judgment to ensure that the educational standards and standards of technique and practice in radiography and allied sciences are maintained at a high level, and that all persons admitted to membership are skilled and competent.

**Complete booklet may be obtained by writing to Sister M. Rose Agnes, Secretary, Board of Examiners, C.S.R.T., St. Joseph's Hospital, Saint John, N.B.*

A Sad Plight!

A Conservative M.P. in Britain, speaking on the paradox of free medical and dental services coupled with declining food imports, said, "Here indeed is a pretty prospect. I can see an endless vista stretching ahead of free false teeth with nothing to bite."

◄ Provincial Notes ►

British Columbia

BURNABY. Construction of a 100-bed hospital and a 2-storey nurses residence in Burnaby is expected to begin shortly. Final plans for the $720,000 project are being prepared by the architects and will be submitted to Hamilton and Associates, government consultants, before construction starts. The recent government survey showed that Burnaby needs 250 beds now and will need 650 within the next few years.

* * * *

CALGARY. The exterior work on the Kelowna General Hospital has been officially reopened after being completely renovated under the auspices of the Kinsmen Club. Walls are now tinted a soft green and gaily decorated with life-size paintings of favourite cartoons. The Kinsmen have donated 12 new cots, a respirator, an oxygen machine, and a radio-phonograph to entertain the small fry. The Kinette Club joined in the program and donated toys, pyjamas, dressing-gowns, and bedroom slippers for the children.

Alberta

CALGARY. The exterior work on the Red Cross Crippled Children's Hospital is nearing completion, and workmen are now going ahead with work inside the building. It is hoped the hospital will be ready for occupancy in about a year. Original plans called for a Y-shaped structure but for the present only 2 wings, 3 storeys high, are being built.

* * * *

INNISFAIL. The Innisfail Hospital Board has approved plans for the construction of an addition to the hospital to house the x-ray department and an emergency ward. The building and new equipment will cost approximately $20,000. Provided these plans are approved by the health and fire departments, construction will begin early in the spring.

* * * *

MAGRATH. Ratepayers in Magrath have voted 10 to 1 in favour of a money by-law for the construction of a new hospital and nurses' home. The hospital will be a 2-storey brick structure with accommodation for 20 patients and will have a major operating room, a modern laboratory, and x-ray facilities. The hospital will have spacious grounds and a special committee has been named to plan attractive landscaping.

Ontario

BARRIE. William H. Wright, owner of the Toronto *Globe and Mail*, has contributed a total of $192,000 to the Barrie and District Memorial Hospital Fund. When the first building campaign was held in 1947, Mr. Wright pledged $40,000 and he has now promised an additional $152,000 if the citizens of Barrie and district can raise the remaining $76,000 needed to put the campaign over the top. It was originally planned to build a new hospital in Barrie but a 50-bed extension to the Royal Victoria Hospital is to be built instead. The cost is estimated at $500,000.

* * * *

LONDON. The cornerstone of the new St. Mary's Hospital for the Chronically Ill has been officially laid by the Rev. J. T. Kidd, Bishop of London. The 220-bed hospital is being built and will be operated by the Sisters of St. Joseph. It will be 6 storeys high and the cost is estimated at $1,000,000.

* * * *

ERINDALE. An 18-room house in Erindale has been purchased by the Ontario government and converted into a 30-bed hospital for alcoholics. The institution, to be known as the Brookside Hospital, is Ontario's first publicly owned hospital for the treatment of alcoholics. At its 1949 session, the Ontario legislature approved the formation of a body to conduct a program of research in alcoholism and to operate a hospital for experimentation in methods of treating alcoholics. The opening of Brookside is the first step in this program.

* * * *

ST. THOMAS. Ratepayers of St. Thomas and Elgin County have voted 2 to 1 in favour of a money by-law for the erection of a $2,200,000 hospital in St. Thomas. The new hospital which is being designed by James Govan of Toronto, will have 3 wings, 5 storeys in height, and be so engineered that 2 more storeys can be added at a later date. It will contain 220 beds and 60 bassinets. After its erection, non-fireproof wings of the present hospital will be torn down and the rest of the building converted into a 65-bed hospital for chronics.

Quebec

MONTREAL. The Grey Nuns, who have been in charge of Notre-Dame Hospital since its inception in 1880, have announced that since the Order is about to staff a new hospital they must terminate their services at Notre-Dame. The Superior General explained that the new 500-bed Maisonneuve Hospital is to be staffed by the Grey Nuns and that the Sisters cannot successfully operate both institutions. The 36 sisters presently working at Notre-Dame will remain on until another order can be found to take their place.

* * * *

QUEBEC. Construction is scheduled to start in the spring on a multi-million dollar medical centre at Laval University, Quebec City. The centre will consist of the following 10 buildings: faculty of medicine, analysis and research laboratory, teaching hospital, convalescent home, nursing school, morgue, school of dentistry, pharmacy school, nuns' residence, hospital entrance. The hospital itself will be 12 storeys high and contain 400 beds, 100 being for cancer

(Concluded on page 64)

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They are the only type of Fire Escape actually suitable for use of children, the sick, the incapacitated.

Recognition by the Federal Government is shown by their ordering eight of these escapes for the large Military Hospital in Quebec City (Hôpital St. Charles).

Regrets never save a life, but efficient Fire Escapes do. The time to install a Fire Escape is *BEFORE* a fire occurs.

DO THIS: A post card will do—just say, "Please Send Me Your Fire Escape Folder." No obligation, well illustrated, interesting.

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Food Poisoning

(Continued from page 27)

applied to any illness resulting from the consumption of food. True ptomaines are nitrogenous bodies formed in the later stages of food decomposition when food is so obviously spoiled that people would normally refuse to eat it. Ptomaines have never been shown conclusively to produce illness when given by mouth although their injection experimentally has sometimes led to illness.

Prevalence

The relative importance of food as a vector in diseases known to be the result of the consumption of contaminated food is suggested by the preliminary report of the U.S.P.H. Service for 1945. In even numbers the cases reported are roughly as follows:

Bacillary dysentry	34,600
Other types of dysentry and G.I. disturbances	11,000
Septic sore throat	10,000
Typhoid and paratyphoid fever	5,600
Undulant fever	5,000
Trichinosis	250

The omission from this report of any reference to botulism or food-borne worm disease points to their relative infrequency.

The prevalence in Ontario of these types of food poisoning is difficult to measure (not a reportable disease) because only the occasional outbreak comes to the attention of the public health authorities, so an accurate estimate is not available. Figures from England and Wales and the U.S. Public Health Service are obtainable and since it would appear that conditions are somewhat similar, similar conclusions might be drawn with respect to Ontario.

During the ten years 1937–46, the Registrar General recorded a total of 246 deaths from food poisoning in England and Wales. This represents an annual death rate of 0.5 per million living. These figures comprise deaths from all forms of food poisoning. Division further than this into causative factors is difficult but at least 94 or over one-third of the 246 deaths were due to infection with Salmonella organisms.

Men appear to die of food poisoning more often than women, 149 males and 97 females. During this period a further analysis of the figures supplied confirms the clinical impression that food poisoning is most serious in the very young and very old. Seasonal investigation shows further the existence of a seasonal peak in the third quarter of the year.

Possibly the most satisfactory statistics from the United States are to be found in the reports of the U.S. Public Health Service. Husseman and Tanner[5] have prepared a summary from these which does not include outbreaks caused by chemicals, shellfish, or other agents, as do the English figures, but does give some basis for comparison.

These authors conclude that the number of cases of food poisoning caused by bacteria more than doubled during the five-year period (1940-44) under comparison. A part of this increase is obviously due to better reporting and increased vigilance by public health groups but, as they state, it is obvious to students in the field that food poisoning is increasing in incidence in spite of the many cases and outbreaks that are not reported.

Continuing their analysis Husseman and Tanner found that the greatest number of cases of food poisoning due to bacteria resulted from eating foods contaminated by staphylococci, streptococci, Salmonella, shigella and eberthella typhosa organisms, with far the greatest number of cases resulting from the staphylococcus type.

In addition to the above there are 9 or 10 other types recorded annually which are offenders to be considered.

Definite figures for Ontario have not been obtainable. During the period 1937 to 1946, deaths from notifiable diseases that were food or water borne averaged 62.4 per year including 3 deaths in 1944 attributed to botulism.[6]

(To be concluded in March)

5. Dorothy L. Husseman, Fred W. Tanner, "New Aspects of the Food Poisoning Problem; J. of the Amer. Dietetic Assoc., Jan., 1947.

6. Report relating to the Registration of Births, Marriages and Deaths in the Province of Ontario for the year ending Dec. 31, 1946. Province of Ontario, 1948.

Problems of Small Hospitals

(Concluded from page 35)

with favoured individual doctors invariably invites resentment on the part of other doctors. The board should never pass resolutions ordering action which may affect the work of the doctors without first referring the matter to the medical staff for a recommendation. When that recommendation is received the board should consider it carefully but should always retain the right to make its own decisions. Sometimes the board may find it necessary to act contrary to the recommendations of the medical staff, but it is very unwise to act at all on matters of importance to the doctors, without first giving the doctors as a group (not as individuals) a chance to consider the matter and to place their united views, or at least their majority views, before the board.

The attitude of the superintendent towards the board should be one of respect for its position of authority and, as in the case of the doctors, should be absolutely impartial. The board should be regarded as a unit. The superintendent should at all costs avoid telephoning and running to individual members with specific problems. This does not mean that he may not seek advice upon some points, sometimes perhaps from members of the board, but there is nothing more disastrous in a hospital than for the superintendent to keep turning to individual members every time a problem arises. The inevitable result of this is to create resentment on the part of those members whose advice is not asked, and the favoured members may develop doubts concerning the competence of the administrator.

An administrator should be capable of making his or her own decisions, not hurriedly, but after considering the policies and instructions of the board and obtaining all the advice available. To keep leaning on individual members of the board for decisions on difficult points is inviting interference and will in the long run create more problems than it will cure. If a superintendent is not capable of making his or her own decisions upon matters within the sphere of the superintendent, then he or she is in the wrong field of activity and should seek some other occupation more suited to his or her talents. ●

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INSTEAD OF	**INSTEAD OF**	**INSTEAD OF**	**INSTEAD OF**
Mayo Intestinal #1, #2 Murphy Intestinal #1, #2 Ferguson #6, #8 Mayo Catgut #1, #2	Mayo Intestinal #3, #4 Murphy Intestinal #3, #4 Ferguson #10, #12 Mayo Catgut #3, #4	Regular Surgeon's #2, #3 Fistula #2, #3 Mayo Trocar #2 Martin's Uterine #4	Regular Surgeon's #4, #5 Fistula #4, #5 Mayo Trocar #3, #4 Martin's Uterine #5, #6
ONE NEEDLE DISPLACES 8	**ONE NEEDLE DISPLACES 8**	**ONE NEEDLE DISPLACES 6**	**ONE NEEDLE DISPLACES 8**

THESE 30 EYED NEEDLES REPRESENT 80% OF THE NEEDLES USED IN ABDOMINAL CLOSURE

Hospital Expenses Reduced by Needle Standardization

Substantial savings are made when surgical staff personnel standardizes on needles as suggested in the above chart. The eyeless needles are always ready and are easier to use. No unthreading. Operating time reduced.

The hospital reduces its inventory and investment. Nurse time is saved by eliminating preparation and sterilization. There is no need to scrub, polish or sharpen the needles.

It pays to standardize on Ethicon Atraloc (Eyeless) Needle Sutures.

ETHICON Sutures

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About Engineering

(Concluded from page 40)

system. Where should a hospital start generating its own electric power? It is advantageous in all regions for the hospital to have its own generating system, but in colder regions where the heating load is carried for six months of the year or where heating and power loads are balanced, it is a paying proposition for the hospital to install its own power system. In addition to the monetary saving during the season when no heating is necessary, the generating plant will act as an emergency stand-by. When a hospital does not have its own generating system, it must have auxiliary stand-by lighting units in the operating and delivery rooms. An emergency lighting unit can be devised from automatic battery sets which can be so arranged that the surgeon in the operating room or the obstetrician in the delivery room will not even notice the change in lighting when the outside power is shut off.

In closing, I would like to state that I feel the administrator should assume a humble attitude in dealing with technical problems. He should make full use of the knowledge of his engineering department and should feel free to call in a consultant if necessary. Hospital engineering problems have become very complex and there have been so many advances recently that, unless a hospital administrator is an engineer himself, it is almost impossible for him to keep up-to-date. Hospital equipment and construction is so expensive that he is in a much safer position if he obtains expert advice before he launches any extensive program of construction or alteration. A mistake on the part of the administrator may not only cost the hospital a considerable sum of money but may also jeopardize the welfare of the patients. Just as a good physician is always prepared to get another opinion on a surgical or medical case, a good administrator should be prepared to get an outside opinion in regard to any organizational or structural change.

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4

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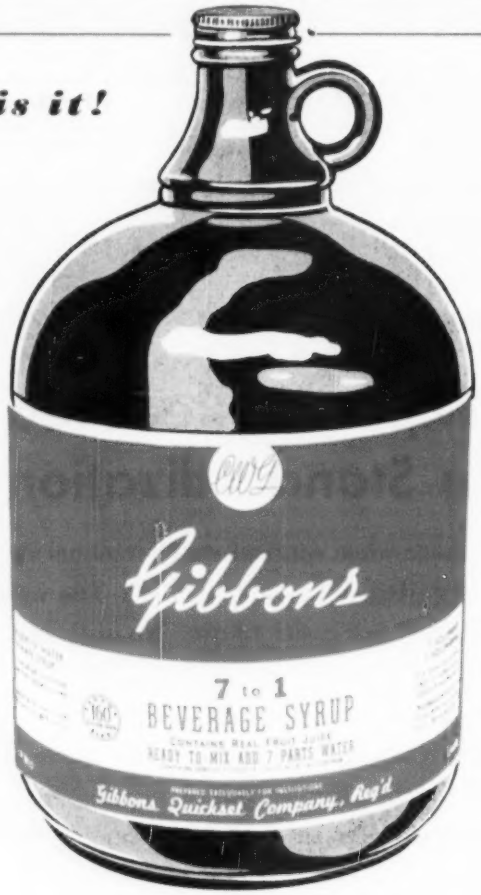

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Texas Hospital Headed by Former Regina Administrator

Clarence C. Gibson, F.A.C.H.A., has accepted the position of administrator at the new Ector County Memorial Hospital, Odessa, Texas. Mr. Gibson has been administrator of the El Paso City County Hospital since 1947 and, prior to that time, was active in the hospital field in Canada. He was superintendent of the Regina General Hospital for some years and, before leaving Canada, was in the service of the Hospital Division, Department of Public Health, Saskatchewan. In 1943, Mr. Gibson was President of the Saskatchewan Hospital Association. The Ector County Memorial Hospital, which he will head, contains approximately 100 beds and 35 bassinets, and was built at a cost of $840,000.

Employee Manual Available

The Publications Department of the American Hospital Association has reprinted the Cleveland Hospital Council's manual on *Training Hospital Employees*. A limited supply of the 360-page manual is available for purchase by Association members. Price is $5.50.

Fund-Raising Services

Available to Canadian Hospitals

The Officers and Directing Staff of the Wells Organizations have engaged in the direction of more than 100 hospital campaigns which have raised a total of over $50,000,000. Each campaign conducted since World War II by Wells Organizations, with one exception, has been over-subscribed. The average percentage of objectives raised on hospital building campaigns in 1947 was 182%; in 1948 it was 115%; and in the Spring of 1949 it rose to 142%.

The establishment of the Wells Organizations of Canada is the realization of the ambition of F. Herbert Wells, Chairman of the Boards of the Wells Organizations. While assisting the Salvation Army in 1940 in a successful $1,000,000 Dominion-wide campaign, Mr. Wells determined to create a quality fund-raising service in Canada which would be easily available to hospitals, churches, colleges and other non-profit organizations.

To-day's fund-raising problems often require many related services such as surveys, organized self-studies and public relations programmes. All of these can be provided by Wells Organizations' staff of more than thirty qualified and experienced fund-raising consultants and directors.

An inquiry pertaining to the fund-raising needs of your hospital will incur no obligation.

Wells Organizations of Canada

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TORONTO, ONTARIO

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Wells Organizations of Ohio
Williams Building
Cleveland, Ohio

Since 1911 the name WELLS has stood for Quality Fund-Raising Campaigns.

Hospital Utilization

(Concluded from page 39)

reported where no method of prepayment exists.

Obviously the rates and costs under universal coverage will be higher when compared with the yardsticks of voluntary prepayment plans. The scope of the task undertaken is much greater. We have always known that the aged, the indigent, and the chronically ill, need more care than the rest of the population and that hospital use would increase with the elimination of restrictions for pre-existing conditions, waiting periods, or limitations on benefit days. Moreover, by paying the full costs of hospital operation—rather than "going rates" or "dollar benefits"—the reported expenditures are also obviously bound to be higher.

The essential difference boils down to one of bookkeeping. After all, the total cost of hospitalized illness in the community must be met from some source. Under an over-all coverage plan, almost all of this total will appear in annual statistical and financial reports. Under a voluntary prepayment plan, something considerably less than this total cost will be met. The remainder of the total cost must be obtained by the hospitals from extra payments from beneficiaries, individual payments from non-beneficiaries, governmental subsidies, deficit payments, and voluntary contributions.

Obviously, also, the rates and costs under universal coverage will be higher when compared with the yardstick of hospital utilization and costs where no prepayment method exists. The reason is the removal of the economic barrier, a factor which also results in higher utilization under the voluntary plans, though to a lesser degree.

The removal of the economic barrier reveals that the amount of illness requiring hospital care is greater than previously indicated. As hospital facilities and services improve, the demand will probably continue to rise. Since we must be realistic about the share of the national income which can be devoted to hospital care, the effect of this increased demand is to place on all concerned—beneficiaries, hospital administrators, doctors, and insurance administrators—an inescapable responsibility to make certain that only legitimate cases are admitted to hospital, that length of stay is reduced to an essential minimum, and that unnecessary expense is avoided. Until such a time as diagnostic services, out-patient services, and the services of physicians in the home and office are provided under a prepayment program, there will remain a constant pressure to stretch the definition of in-patient care.

There is also a clear need to examine our facilities and services for the care of the convalescent, the chronically ill, and the aged. We must make certain that the best and most economical use is being made of facilities and services outside of the more expensive general hospital. Such an examination is desirable in any circumstances. Under an over-all hospital care insurance program it is imperative!

World Famous Surgeon Visits Brooklyn Firm

Left to right—Charles P. Collins, Vice-President; Mrs. Finsterer; Dr. Hans Finsterer; C. Carroll Adams, Vice-President; Benjamin F. Hirsch, Executive Vice-President.

DR. HANS FINISTERER, selected Master of Surgery by the International College of Surgeons, visited the Brooklyn laboratory of Davis & Geck, Inc., suture manufacturing subsidiary of American Cyanamid Company. Dr. Finsterer, 72-year old Professor at the University of Vienna, who is the fifth surgeon to receive the honor in 14 years, came to Brooklyn following a visit with President Truman in Washington. The Doctor is noted for his work in abdominal surgery, having performed more than 8,000 gastric resections (partial or complete removal of the stomach) using local anesthesia only.

Dr. Finsterer commented on the rapid advances in surgery which have taken place since he first started practicing about 1898. Pointing out the extensive improvements in administering of anesthetics, the basis upon which these advances have been made, he stressed the importance of surgical materials and instruments as an adjunct to the skill of the surgeon.

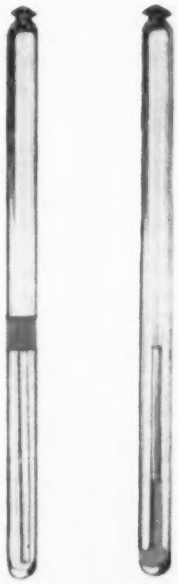
Dr. Finisterer was pleased to receive from B. F. Hirsch, Executive Vice-President of the company, the offer of a supply of certain products which cannot be obtained in Austria at the present time.

Introducing a New Formula Control

INFORM CONTROLS

AN AID IN

Control of Epidemic Infant Diarrhoea



Before After

The outbreak of Epidemic Infant Diarrhoea has been frequent. Too often the cause has not been specifically isolated but it has been clearly shown that "terminal heating" of Formulas markedly reduces the incidence of outbreak.

Recent studies by both the American Hospital Association and the American Pediatric Association have resulted in recommendations for the standardization of Infant Formula Techniques by either the autoclave method at 230° F.—for 10 minutes OR at 212° F.—for 25 minutes.

Inform Controls have been developed for use with the 230° F. 10 minute autoclave technique.

The Inform Control consists of a pellet suspended in a glass tube. The tube is placed in a formula bottle which has been filled with water to the normal level of feedings (about 3 ozs.).

The Inform Control test bottle is then nippled, capped and placed in the centre of the formula load in cylindrical autoclaves and one-third and two-thirds of the way back in the rectangular types.

The Pellet in the Inform Control will melt only when the temperature reaches 230° F. for the time necessary to ensure bacteriologically acceptable formula.

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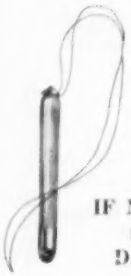
Smith & Underwood sole manufacturers Diack and Inform Controls

AT A GLANCE

Method of

PREVENTING INFECTION*



IF NOT MELTED the pack is DANGEROUS

IF MELTED the pack is perfectly SAFE

★ Before autoclaving, place a *Diack Control* at the centre of each large bundle of dressings, particularly in the large bundles located at the bottom of the chamber. Allow the long threads to extend out of the packs.

When the charge has been run each pack of dressings may be checked for complete sterility by pulling the *Diack* out of the bundle. Examine the tablet; if melted, the dressings are SAFE!

INGRAM & BELL

◄ Book Reviews ►

TECHNIQUES OF SUPERVISION IN PUBLIC HEALTH NURSING. By Ruth B. Freeman, R.N., B.S., M.A., Administrator, Nursing Services, American National Red Cross. Pp. 466. Second Edition. Price $5.75. Published by W. B. Saunders Co., Philadelphia. Canadian Agents, McAinsh & Co. Ltd., Toronto. 1949.

This volume places clearly before the reader the specific techniques and methods of supervision in the field of public health nursing. In the first chapters, Miss Freeman discusses the philosophy and purpose of supervision, its "why" and "what", and then moves on quickly to the more practical considerations of establishing principles and ways to help the public health supervisor solve the problems she will meet in the course of her work. Difficulties and problems which arise with relative frequency have been singled out for special study. Chapters deal with such topics as planning a supervisory program, planning a staff education program, evaluating staff performance, and helping the nurse to plan her work effectively. At the end of the book, some of the questions to which no satisfactory answer has yet been found are discussed. Each chapter is divided into clearly marked sections and to each is appended a suggested reading list.

Since the publication of the first edition of this book in 1944, certain trends in nursing and in education and guidance have crystallized to the point where they affect supervisory practice. As a result, in this second edition numerous changes and additions have been made to conform with these new developments. The chapter, "What is Supervision?" has been rewritten entirely.

This volume is directed chiefly to supervisors in public health nursing but it should prove useful to staff nurse teachers as well for many of the fundamentals of supervision can be invaluable to the staff nurse in her relationships with families, students, and subsidiary workers. The book is recommended as a worthwhile addition to the libraries of all those in a supervisory capacity.

COMMUNICABLE DISEASE NURSING. By Theresa I. Lynch, R.N., Ed.D., Dean of the School of Nursing, University of Pennsylvania; formerly Superintendent of Nurses and Director of Instruction, The Willard Parker Hospital, New York City. Second edition. Pp. 776. Illustrated. Price $5.50. Published by C. V. Mosby Co., St. Louis, Mo. Canadian agents, McAinsh & Co., Ltd., Toronto, 1949.

This book presents the subject of communicable disease nursing as it is taught in modern hospitals and as it may be practised in both hospitals and homes. In addition to presenting the technical aspects of communicable disease nursing, the author's purpose is to show the nurse the part she may play in the community by aiding in the prevention and control of communicable diseases.

The subject matter is divided into five sections: orientation to communicable disease nursing, medical aspects and nursing care of communicable diseases, tuberculosis, venereal diseases, and communicable diseases and the community. A brief discussion of infectious diseases which are not so common and of those with which the nurse is already familiar are included in an appendix.

In this second edition, the author has reviewed and revised all subject matter and brought it up-to-date. Following each chapter are lists of references and of suggested readings, and there are 131 text illustrations and 4 colour plates.

Communicable Disease Nursing is intended as a guide for instructors, a text for students, and a ready reference book for nurses. The author's able treatment of the subject should certainly help to carry out that intention.

Any further steps to remedy the nursing shortage in Canada must be undertaken by the Dominion and Provincial governments, which alone have the power, financial and otherwise, to introduce the reforms suggested. It is with them and not with the nursing profession that the remedy lies.—*Rae Chittick, Reg.N.*

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Provincial Notes

(Concluded from page 54)

patients. Because of the scope of the proposed scheme, units will be built singly as funds become available.

* * * *

SHERBROOKE. Harry Norton, Ayerscliff industrialist, has bequeathed to the Sherbrooke Hospital $150,000. Mr. Norton was an active supporter of the hospital, a past president of its board of directors, and a member of the committee responsible for the new hospital building now under construction. This bequest brings to $250,000 the amount of money which has been donated to the new hospital by the Norton family.

Nova Scotia

TRURO. The new 50-bed addition to Colchester County Hospital is nearing completion and is expected to be ready for occupancy this month. As soon as it can be used, the old part of the hospital is to be completely renovated. The kitchen in the new wing will cater to the entire hospital, and the former kitchen space will become an x-ray department. An additional operating room is to be established and the entire interior will be repainted in pleasant pastel tones. ●

EXPERIENCED OPERATING ROOM SUPERVISOR REQUIRED

For 150-bed general hospital, 48-hour week, 4 weeks vacation every year. Those interested are asked to apply to Superintendent of Nurses, Public General Hospital, Chatham, Ontario, and to state their qualifications, experience, age, and salary expected.

WANTED — POSITION AS BUSINESS MANAGER OR ASSISTANT SUPERINTENDENT

Experienced business manager or assistant superintendent available for large hospital. Would consider position of superintendent in smaller institution. Formerly a Canadian, has been employed as business manager of 508-bed hospital in Buffalo for 4 years. Two years in the R.C.A.F. Position in one of the Western provinces or Ontario preferred. Available at once. Box 292, The Canadian Hospital, 57 Bloor St. W., Toronto.

There is no one more unfortunate than the man, who has never been unfortunate, for it has never been in his power to try himself.—*Seneca.*

ADMINISTRATOR WANTED

A vacancy exists for a hospital Superintendent for the General Hospital at St. John's, Nfld. (265 beds). Interested applicants should communicate with the Deputy Minister of Health, St. John's, Nfld.

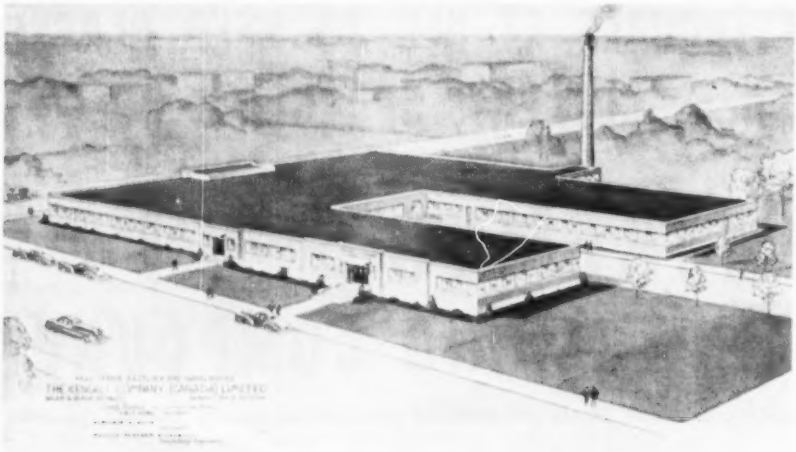
EXPERIENCED HOSPITAL DIETITIAN REQUIRED

For new hospital, opening end of March, 1950, with initial complement of 125 beds. Excellent opportunity for a person prepared to organize a modern and spacious dietary department. Salary open. Applications together with references to be addressed to Jack L. Bateman, Superintendent, Stratford General Hospital, Stratford, Ontario.

IMMEDIATELY AVAILABLE

Qualified hospital administrator. Fine record, excellent training, good experience in managing. Full details supplied upon request. Personal interview if desired. Anywhere in Canada. Write Box No. 232A, Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

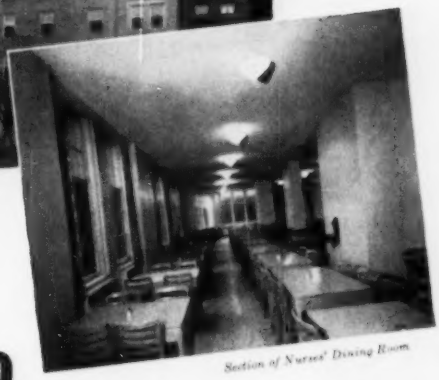
New Home of Bauer & Black . . .



AN artist's conception of the new home of The Kendall Company (Canada) Limited, which is now in process of construction. It is more familiarly known to many by the name of its major division, Bauer & Black. This Company is well-known for its line of Curity Surgical Dressings, Elastic Goods and Sutures.

Situated on a seven-acre site to the north of O'Connor Drive on Curity Avenue, this modern new single story plant is of red brick and steel frame construction. It will be used for the establishment of special manufacturing phases, and accommodation of present operations and offices now located at 419 Coxwell Avenue, Toronto.

Present plans call for attractive landscaping on the grounds adjacent to the plant. The remaining space will be used for future plant expansion, recreation grounds and off-street parking.



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Please send me information on refrigeration equipment for

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Occupational Therapy

(Concluded from page 31)

then be swung into action for the individual as required.

The Physically Handicapped

In our general hospitals the stress has been on removing chronically ill and disabled persons from the general wards to make room for others, whose eventual cure is more assured. While this is essential, what happens to the one individual who is severely handicapped physically, or so considers himself, when he is suddenly sent out into the world? What happens to him if he cannot be discharged for physical reasons, but "plugs a bed" in the institution? What is the responsibility of the general hospital toward these unemployable disabled? Whose responsibility are they?

These questions have been left unanswered by all of us for a long time. The community, which we serve, continues to be responsible, in the end, for keeping these persons alive, be it through charity or government agencies.

When the discharge from hospital is arranged, these chronically disabled individuals would be carried along through a rehabilitation program at a convalescent hospital, or from their homes at separate civilian rehabilitation centres. Here, vocational and social rehabilitation is continued.

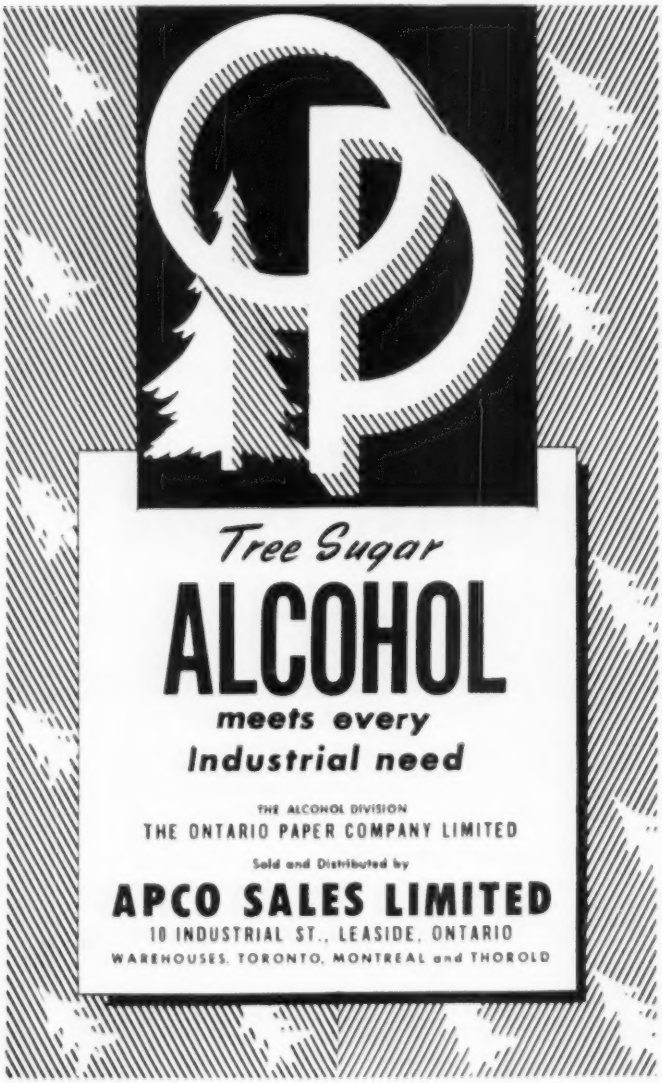
Occupational therapy is one cog in the wheel of progress, that the successful re-establishment of each disabled person may be ensured.

As with nurses and physiotherapists, there is an acute shortage of trained occupational therapists. With but one school in Canada, our efforts to achieve our goal will be frustrated until sufficient training schools are established.

What we need, first, is not only more general hospitals and special facilities but sufficient and adequately trained personnel to staff those we have. Then the existing programs may be enlarged in hospital centres, that these may act as pilot projects to show the way.

Progress will be slow, let us do first things first!

When my way is too rough for my feet, or too steep for my strength, I get off to some smooth velvet path which fancy has scattered over with rosebuds of delights; and, having taken a few turns in it, come back strengthened and refreshed.—*Sterne.*



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CANADA'S FOREMOST CRAFT SUPPLY HOUSE

Too Many Beds?

(Continued from page 28)

it as a routine occurrence. In 1929 there were 103.3 admissions per thousand population, and in 1947 there were 164.9 admissions per thousand population, an increase of 62 per cent.

Reasons for Demand

There are several reasons for this increased demand for hospitalization:

(a) The reluctance of physicians to treat patients at home or in the office;

(b) Modern methods of treatment which require skilled administration;

(c) Use of modern "wonder drugs" which makes skilled supervision of the patient imperative;

(d) Insurance plans and legislation such as the Maternity Hospitalization Act, which makes available to the patient free, or practically free, hospitalization;

(e) The change to small family dwellings in which there is no room to accommodate the sick;

(f) An increasing consciousness on the part of the public of the value of better health.

The increased demand for hospitalization may be maintained indefinitely or there may be a levelling off point. Although the incidence jumped 62 per cent between 1929 and 1947, there appears to have been a drop during the past two years. In 1946, there were, in round numbers, 140,000 admissions, in 1947, 139,000 admissions and in 1948, 135,000. If our statistics can be relied upon, this would appear to indicate that we have reached the peak in the demand for hospital services, and have arrived at the levelling off point.

Summary

In conclusion, I would suggest that the answers to the following questions will give us direction in assessing our bed requirements:

1. Under existing circumstances, is the demand for hospital services sufficient to maintain the economical level of 70 per cent occupancy?

2. If the occupancy level is not maintained, could we afford the higher patient day cost which would result from lower occupancy?

3. In the event of all residents of the province being covered by a hospital insurance scheme, what would be the influence on our hospitalization incidence?

4. If, as our statistics would seem

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MAY 29—JUNE 9, 1950 TORONTO, ONTARIO

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to indicate, the levelling off has taken place in the demand for hospital services in prosperous times, what might happen if hard times return?

5. Does part of the present high rate of hospitalization in Alberta arise because certain cases are admitted who might reasonably be taken care of at home?

Windsor Doctor Absolved In Death of Twins

Dr. M. S. Douglas of Windsor, Ont., was absolved by a coroner's jury from responsibility in the death of premature twins who were left at home, apparently not living, when he rushed the hemorrhaging mother to hospital. The incident occurred some four years ago but was brought to light recently by Mayor Rheaume, who has had some sharp tilts with Windsor doctors in connection with the public investigation last summer of the administration of the Metropolitan Hospital. At that time, the participation of the (then) superintendent, with the mayor and others, in the much discussed Detroit party received considerable publicity.

The premature twins were of only 23 to 25 weeks gestation and of about one to one and a half pounds weight. The obstetrician had pronounced them dead, and as the mother was bleeding badly had rushed her to hospital. Later, when an ambulance driver returned to the house to take the bodies to the undertaker's, he found them breathing. The infants were then taken to the Metropolitan Hospital where they ceased breathing the next day.

The jury found that the twins died a natural death due to premature birth and to the fact that they were poorly developed. This cleared the doctor of responsibility. The jury did add, however, that in unusual cases of this nature, ambulance drivers and doctors should be compelled to submit a full and detailed report to the Crown Attorney.

Little girl: Daddy, why do editors refer to themselves as "we"?

Daddy: So that the fellow who doesn't like what's printed will think there are too many for him to lick.

THE BUYERS' DIRECTORY

An Alphabetical Directory of Equipment, Supplies, Building Materials and Specialties, with Names of Suppliers.

If you wish to obtain further particular regarding sources of supplies of any kind, we shall be glad to secure the information for you. Please write The Canadian Hospital, 57 Bloor Street West, Toronto 5, Ont.

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- Johnson & Johnson, Limited, Montreal.

BABY FOODS
- H. J. Heinz Co. of Canada, Ltd., Toronto.

BABY POWDER
- Colgate-Palmolive-Peet Co., Ltd., Toronto.
- Johnson & Johnson Ltd., Montreal.
- Merck & Co. Ltd., Montreal.

THE BUYERS' DIRECTORY

BAGS, LAUNDRY
Bland & Co., Ltd., Montreal.
Dalglish Chemicals, Limited, Toronto 17.
Dominion Textile Co., Ltd., Montreal.
Lac-Mac Limited, London, Ont.
Gordon Mackay & Co. Ltd., Toronto.
G. A. Hardie & Co., Ltd., Toronto.

BANDAGES, CREPE TYPE
Smith & Nephew, Limited, Montreal.

BANDAGES, ELASTIC ADHESIVE
Smith & Nephew, Limited, Montreal.

BANDAGES, GAUZE
Bauer & Black, Division of the Kendall Co. (Canada) Ltd., Toronto.
Johnson & Johnson, Ltd., Montreal.
Smith & Nephew Ltd., Montreal.

BAND-AID ADHESIVE BANDAGES
Johnson & Johnson, Limited, Montreal.

BANDAGES AND SPLINTS
Plaster of Paris
Bauer & Black, Division of the Kendall Co. (Canada) Ltd., Toronto.
Johnson & Johnson, Limited, Montreal.

BASAL METABOLORS
Canadian Liquid Air Co. Ltd., Montreal.
X-Ray & Radium Industries, Ltd., Toronto.

BATH ROBES
Corbett-Cowley, Ltd., Toronto.
CorDest Garments, Ltd., London, Ont.
Lac-Mac Limited, London, Ont.

BED GOWNS
Bland & Co., Ltd., Montreal.
Corbett-Cowley, Ltd., Toronto.
CorDest Garments, Ltd., London, Ont.
Lac-Mac Limited, London, Ont.
Wilkins, Robt. C. Co. Ltd., Farnham, Que.

BED SPREADS
CorDest Garments, Ltd., London, Ont.
Dominion Textile Co., Ltd., Montreal.
Hotel & Hospital Supply Co., Toronto.
G. A. Hardie & Co., Ltd., Toronto.
Textile Products Co., Ltd., Toronto.

BEDS, HOSPITAL TYPE
Dominion Metalware Industries Limited, Long Branch.
T. Eaton Co. Ltd., Toronto.
Ives Bedding Co., Limited, Cornwall, Ont.
Metal Craft Co., Ltd., Grimsby, Ont.
Metal Fabricators, Ltd., Tillsonburg, Ont.
Parkhill Bedding, Ltd., Winnipeg.
Simmons Limited, Montreal.
Robert Simpson Co. Ltd., Toronto.

BEVERAGE COOLERS
Coca-Cola Ltd., Toronto.
Frigidaire Products of Canada Ltd., Leaside, Ont.
Universal Cooler Co. Ltd., Brantford, Ont.

BEVERAGES, FOOD
Coca-Cola Ltd., Toronto.
Harold P. Cowan Importers, Ltd., Toronto.
Gibbons Quickset Desserts, Toronto.
Juice Industries, Inc., Dunedin, Florida.
J. H. Stafford Industries, Ltd., Toronto.
Vi-Tone Products, Ltd., Hamilton, Ont.

BIOLOGICALS: (Antitoxins, Serums, Vaccines, etc.)
Cutter Laboratories, International, Toronto.
Ortho Pharmaceutical Corpn. (Canada) Ltd., Toronto.
Parke, Davis & Co., Ltd., Walkerville, Ont.
Sharp & Dohme (Canada) Ltd., Toronto.
E. R. Squibb & Sons of Canada Ltd., Montreal.

BIRTH CERTIFICATES
Franklin C. Hollister Co., Chicago, Ill.
Physicians' Record Co., Chicago, Ill.

BISCUITS
Christie Brown & Co., Ltd., Toronto.

BLANKETS, FLANNELETTE
Ayers Limited, Lachute Mills, Que.
Cassidy's Limited, Montreal.
Dominion Textile Co., Ltd., Montreal.
T. Eaton Co., Ltd., Toronto.
Gordon Mackay & Co., Ltd., Toronto.
Hotel & Hospital Supply Co., Toronto.
Robert Simpson Co. Ltd., Toronto.
Textile Products Co., Ltd., Toronto.

BLANKET WARMERS
American Sterilizer Co., Erie, Pa.
Dominion Metalware Industries Limited, Long Branch.
Metal Craft Co., Ltd., Grimsby, Ont.
Metal Fabricators, Ltd., Tillsonburg, Ont.

BLOOD CULTURE BOTTLES
Becton, Dickinson & Co., Rutherford, N.J.

BLOOD FRACTIONS
Cutter Laboratories, International, Toronto.

BLOOD PRESERVATIVES
Abbott Laboratories, Ltd., Montreal.
J. F. Hartz Co., Limited, Toronto.

BLOOD SOLVENT
Fisher & Burpe, Limited, Winnipeg.

BLOOD TRANSFUSION SETS
Baxter Laboratories of Canada Ltd., Acton, Ont.
Cutter Laboratories, International, Toronto.
Ingram & Bell, Ltd., Toronto.

BODY RUB
Fisher & Burpe, Limited, Winnipeg.

BOILERS
Crane Limited, Montreal.

BOOKS, MEDICAL and HOSPITAL ADMINISTRATION
Macmillan Co. of Canada, Ltd., Toronto.
Physicians' Record Co., Chicago, Ill.

BOOKKEEPING—CALCULATING MACHINES
National Cash Register Co. of Canada, Ltd., Toronto.
Remington Rand Limited, Toronto.

BROOMS, ELECTRIC
G. H. Wood & Co., Ltd., Toronto.

BRUSHES AND BROOMS
Dustbane Products, Ltd., Ottawa.

CABINETS
Chart, History and Special
Dominion Metalware Industries Limited, Long Branch.
Metal Craft Co., Ltd., Grimsby, Ont.
Metal Fabricators Ltd., Tillsonburg ,Ont.
Office Specialty Mfg. Co., Ltd., Newmarket, Ont.
J. & J. Taylor, Ltd., Toronto.
Westeel Products Ltd., Toronto.
Filing
Office Specialty Mfg. Co. Ltd., Newmarket, Ont.
Remington Rand Limited, Toronto.

CABINET LOCKS
Corbin Lock Co. of Canada, Limited, Belleville, Ont.

CAFETERIA FURNITURE
Arnold Banfield & Co., Ltd., Toronto.
Cassidy's Limited, Montreal.
T. Eaton Co., Ltd., Toronto.
Robert Simpson Co. Ltd., Toronto.

CAKE MIX
Gibbons Quick-Set Desserts, Toronto.

CALL SYSTEMS
Cannon Electric Co. Limited, Toronto.
Edwards of Canada, Ltd., Montreal.
Electro-Vox, Inc., Montreal.
Northern Electric Co. Ltd., Montreal.

CAMERAS
70 m.m. and Accessories
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B. O. P., Montreal.
General Electric X-Ray Corporation Limited, Montreal.

CANCER CONTROL FORMS
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Bland & Co., Ltd., Montreal.
Corbett-Cowley, Ltd., Toronto.
CorDest Garments, Ltd., London, Ont.
Johnson & Johnson, Ltd., Montreal.
Lac-Mac Limited, London, Ont.

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Bland & Co., Ltd., Montreal.
Corbett-Cowley, Ltd., Toronto.
CorDest Garments, Ltd., London, Ont.
Lac-Mac Limited, London, Ont.

CARBONATED DRINKS
Coca-Cola Ltd., Toronto.

CASH REGISTERS
National Cash Register Co. of Canada Ltd., Toronto.

CAST PADDING, LATEX FOAM
Dunlop Tire & Rubber Goods Co., Ltd., Toronto.
Goodyear Tire & Rubber Co. of Canada Ltd., Toronto.

CASTERS
Arnold Banfield & Co., Ltd., Toronto.
Canadian Fairbanks-Morse Co., Ltd., Montreal.
Darnell Corp. of Canada, Ltd., Long Branch, Ont.
Fischer Bearings (Canada) Ltd., Toronto.
Flintkote Co. of Canada, Ltd., Long Branch, Ont.
Metal Craft Co., Ltd., Grimsby, Ont.
Stanley Brock, Limited, Winnipeg.
Stewart-Warner-Alemite Corp. of Canada, Ltd., (Bassick Division) Belleville, Ont.
Viceroy Mfg. Co. Ltd., Toronto.

CATHETERIZATION PRESSURE RECORDING APPARATUS
Ferranti Electric Ltd., Mt. Dennis, Ont.
Smith & Stone Limited, Georgetown, Ont.

CATHETERS
American Cystoscope Makers, Inc., New York.
Canadian Liquid Air Co. Ltd., Montreal.
Clay-Adams Co., Inc., New York.
Sterling Rubber Co., Ltd., Guelph, Ont.

CATHODE-RAY APPARATUS
Ferranti Electric Ltd., Mt. Dennis, Ont.
Smith & Stone Limited, Georgetown, Ont.

CAUTERIES
American Cystoscope Makers, Inc., New York.

CELLULOSE DRESSINGS; BANDAGES
Bauer & Black Division of the Kendall Co. (Canada) Ltd., Toronto.
Johnson & Johnson, Ltd., Montreal.

CHAIRS, METAL
Cassidy's Limited, Montreal.
Dominion Metalware Industries Limited, Long Branch.
Metal Craft Co., Ltd., Grimsby, Ont.
Metal Fabricators Ltd., Tillsonburg, Ont.
Office Specialty Mfg. Co., Ltd., Newmarket, Ont.
Parkhill Bedding, Ltd., Winnipeg.
Simmons Limited, Montreal.

CHAIRS
Office, Wood or Steel
Office Specialty Mfg. Co., Ltd., Newmarket, Ont.
Remington Rand Limited, Toronto.

CHAIRS, WHEEL
Canadian Fairbanks-Morse Co., Ltd., Montreal.

CHAIRS, WOOD
Cassidy's Limited, Montreal.
T. Eaton Co., Ltd., Toronto.

CHARTS, ANATOMICAL
Clay-Adams Co., Inc., New York.

CHINA
Bell, Rinfret & Co., Ltd., Montreal.
British & Colonial Trading Co., Ltd., Toronto.
Cassidy's Limited, Montreal.
T. Eaton Co., Ltd., Toronto.
Hotel & Hospital Supply Co., Toronto.

CHLOROFORM
Merck & Co. Ltd., Montreal.
E. R. Squibb & Sons of Canada, Ltd., Montreal.

CHOPPING MACHINES
G. S. Blakeslee & Co., Ltd., Toronto.
General Steel Wares, Ltd., Toronto.
Hobart Mfg. Co., Ltd., Toronto.
Toledo Scale Co. of Canada, Limited, Windsor, Ont.

CITRUS PRODUCTS
Harold P. Cowan Importers, Ltd., Toronto.
Juice Industries Inc., Dunedin, Florida.
J. H. Stafford Industries, Ltd., Toronto.
Supereme Food Products, Ltd., Montreal.

CLEANSING AGENTS
Floors, Etc.
Colgate-Palmolive-Peet Co., Ltd., Toronto.
Dustbane Products, Ltd., Ottawa.
Dye & Chemical Co. of Canada, Ltd., Kingston, Ont.
Flintkote Co. of Canada, Ltd., Long Branch, Ont.
Gordon A. MacEachern, Toronto.
Huntington Laboratories of Canada, Ltd., Toronto.
Hygiene Products, Ltd., Dorval, Que.
McKague Chemical Co. Limited, Toronto.
West Disinfecting Co. Ltd., Montreal.

Laundry
Colgate-Palmolive-Peet Co., Ltd., Toronto.
Dye & Chemical Co. of Canada, Ltd., Kingston, Ont.
McKague Chemical Co., Limited, Toronto.
Stanley Brock, Limited, Winnipeg.

CLOCK SYSTEMS
Paul Chaput, Ltée., Montreal.
Edwards of Canada, Ltd., Montreal.
Electro-Vox, Inc., Montreal.

CLOSERS, DOOR
Corbin Lock Co. of Canada, Limited, Belleville, Ont.

CLOTHING, HOSPITAL
Bland & Co., Ltd., Montreal.
Corbett-Cowley, Ltd., Toronto.
CorDest Garments, Ltd., London, Ont.
Lac-Mac Limited, London, Ont.
Wilkins, Robert C. Co. Ltd., Farnham, Que.

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Berkel Products Co., Limited, Toronto.
Hobart Mfg. Co., Ltd., Toronto.

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Armstrong Cork, Canada Ltd., Montreal.
Canadian Ice Machine Co. Ltd., Toronto.
Universal Cooler Co. Ltd., Brantford, Ont.

COLLAR FINISHING PRESSES
Canadian Laundry Machinery Co., Ltd., Toronto.

COMFORTERS
Corbett-Cowley, Ltd., Toronto.
Gordon Mackay & Co., Ltd., Toronto.
Howard's Bedding, Ltd., Ottawa.
Parkhill Bedding Ltd., Winnipeg.
Sleepmaster, Ltd., Toronto.
Textile Products Co., Ltd., Toronto.

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Edwards of Canada Ltd., Montreal.
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Ingram & Bell, Ltd., Toronto.
The Stevens Companies, Toronto.
Smith & Underwood, Royal Oak, Mich.

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Dominion Metalware Industries Limited, Long Branch.
General Steel Wares, Ltd., Toronto.
Kitchen Installations Ltd., Ajax, Ont.
Metal Craft Co., Ltd., Grimsby, Ont.
S. H. Newman Co. Ltd., Toronto.
Robert Simpson Co. Ltd., Toronto.
Wrought Iron Range Co. Ltd., Toronto.

COOKING UTENSILS

Aluminum Goods Limited, Toronto.
Bell, Rinfret & Co. Ltd., Montreal.
British & Colonial Trading Co., Ltd., Toronto.
Ellett Copper & Brass Co., Ltd., Vancouver.
General Steel Wares, Limited, Toronto.
Kitchen Installations Ltd., Ajax, Ont.
Neptune Meters, Ltd., Long Branch, Ont.
S. H. Newman Co. Ltd., Toronto.
Vollrath Company, Sheboygan, Wis.

CORKS, CORK TILE, SPECIALTIES

Armstrong Cork, Canada Ltd., Montreal.

CORN STARCH AND SYRUPS

Canada Starch Co., Ltd., Montreal.

COTS, FINGER, ETC.

Sterling Rubber Co., Ltd., Guelph, Ont.

COTS, METAL

Metal Craft Co., Ltd., Grimsby, Ont.
Metal Fabricators, Ltd., Tillsonburg, Ont.
Parkhill Bedding, Ltd., Winnipeg.
Simmons Limited, Montreal.

COTTON BALLS

Bauer & Black, Division of the Kendall Co. (Canada) Ltd., Toronto.
Johnson & Johnson, Limited, Montreal.

CRIBS, CHILDREN'S

Dominion Metalware Industries Limited, Long Branch.
T. Eaton Co. Ltd., Toronto.
Ives Bedding Co., Limited, Cornwall, Ont.
Metal Craft Co., Ltd., Grimsby, Ont.
Metal Fabricators, Ltd., Tillsonburg, Ont.
Parkhill Bedding, Ltd., Winnipeg.
Simmons Limited, Montreal.

CRINOLINE

Bauer & Black Division of the Kendall Co. (Canada) Ltd., Toronto.
Johnson & Johnson, Limited, Montreal.

CROSS AGGLUTINATION VIBRATOR

Vendall Limited, Toronto.

CUBICLES

Dominion Metalware Industries Limited, Long Branch.
T. Eaton Co., Ltd., Toronto.
Metal Craft Co., Ltd., Grimsby, Ont.
Metal Fabricators, Ltd., Tillsonburg, Ont.
Robert Simpson Co. Ltd., Toronto.
Surgical Supplies (Canada) Ltd., Toronto.
Westeel Products Ltd., Toronto.

CUPS—PAPER FOR HOT AND COLD LIQUIDS

Dixie Cup Co. (Canada) Ltd., Brampton, Ont.
Globe Envelopes, Ltd., Toronto.
Lily Cups, Limited, Toronto.
Victoria Paper & Twine Co., Ltd., Toronto.
G. H. Wood & Co. Ltd., Toronto.

CURTAIN AND BLANKET FINISHING EQUIPMENT

Canadian Hoffman Machinery Co., Ltd., Toronto.
Canadian Laundry Machinery Co., Ltd., Toronto.
J. H. Connor & Son, Limited, Ottawa.
Stanley Brock, Limited, Winnipeg.

CUSTARD POWDERS

Gibbons Quickset Desserts, Toronto.
S. Gumpert Co. of Canada, Ltd., Toronto.
"Junket" Brand Foods, Toronto.
J. H. Stafford Industries, Ltd., Toronto.
Supereme Food Products, Ltd., Montreal.

CUTLERY, TABLE

Bell, Rinfret & Co. Ltd., Toronto.
British & Colonial Trading Co., Ltd., Toronto.
Cassidy's Limited, Montreal.
Hotel & Hospital Supply Co., Toronto.
McGlashan-Clarke Co., Ltd., Niagara Falls, Ont.

CUTTERS, BANDAGE AND GAUZE

W. J. Westaway, Ltd., Hamilton.

CYSTOSCOPES

American Cystoscope Makers, Inc., New York.
Ingram & Bell, Ltd., Toronto.

DEEP THERAPY LAMPS

Burke Electric & X-Ray Co., Ltd., Toronto.
Casgrain & Charbonneau, Ltée., Montreal.
Ferranti Electric Ltd., Mount Dennis, Ont.
Fisher & Burpe Limited, Winnipeg.
General Electric X-Ray Corporation Ltd., Toronto.
Hanovia Chemical & Mfg. Co., Newark, N.J.
J. F. Hartz Co., Ltd., Toronto.
Ingram & Bell, Ltd., Toronto.
The Stevens Companies, Toronto.

DENTAL INSTRUMENTS

Becton, Dickinson & Co., Rutherford, N.J.

DEODORANTS

Cody Paper Products, Limited, Saint John, N.B.
Dustbane Products, Ltd., Ottawa, Ont.
Thomas Gibson & Co., Ltd., Toronto.
Huntington Laboratories of Canada, Ltd., Toronto.
Hygiene Products, Ltd., Dorval, Que.
West Disinfecting Co., Ltd., Montreal.
G. H. Wood & Co., Ltd., Toronto.

DESKS, NURSES' STATIONS

Dominion Metalware Industries Limited, Long Branch.
Metal Craft Co., Ltd., Grimsby, Ont.
Metal Fabricators Ltd., Tillsonburg, Ont.
Office Specialty Mfg. Co., Ltd., Newmarket, Ont.
Remington Rand Limited, Toronto.
Simmons Limited, Montreal.
Robert Simpson Co. Ltd., Toronto.

Office, Wood or Steel

Office Specialty Mfg. Co., Ltd., Newmarket Ont.

DESSERTS

Gibbons Quickset Desserts, Toronto.
S. Gumpert Co. of Canada Ltd., Toronto.
J. H. Stafford Industries, Ltd., Toronto.
Supereme Food Products, Ltd., Montreal.

DEXTROSOL

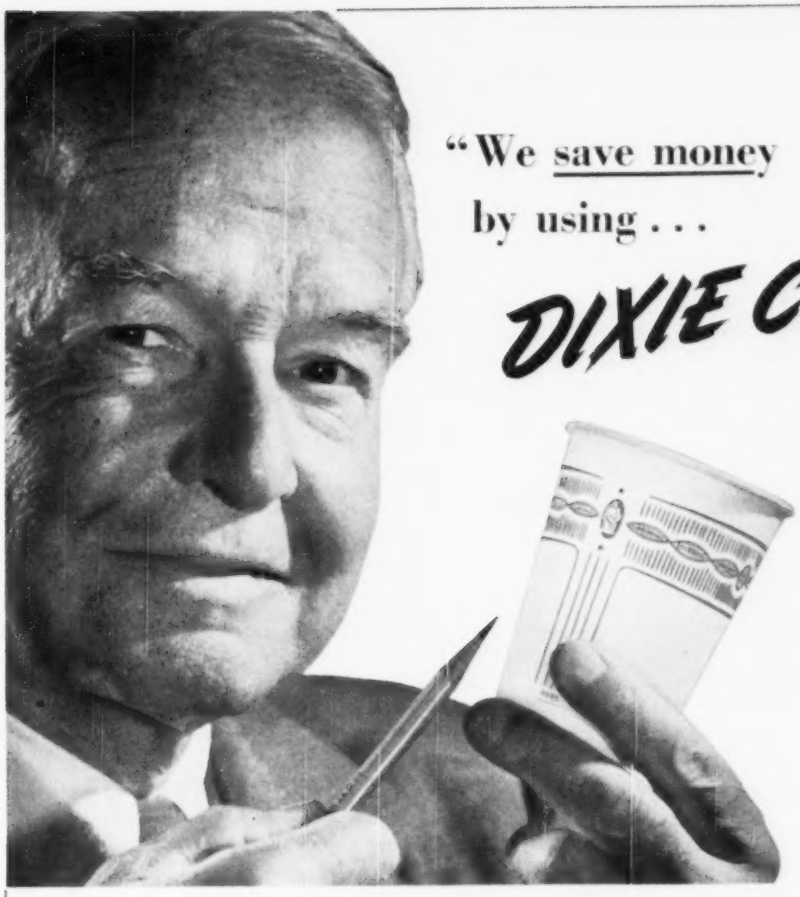
Canada Starch Co., Ltd., Montreal.
"Junket" Brand Foods, Toronto.

DIAGNOSTIC EQUIPMENT and SUPPLIES

Ferranti Electric Ltd., Mt. Dennis, Ont.
Surgical Supplies (Canada) Ltd., Toronto.

DIAPERS

Bauer & Black, Division of the Kendall Co. (Canada) Ltd., Toronto.
Gordon Mackay & Co., Ltd., Toronto.
Lac-Mac Limited, London, Ont.



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For fruit and vegetable juices.

COLD DRINK CUPS

For milk, soft drinks, iced tea, iced coffee.

ICE CREAM CUPS

For ice cream, fruits, puddings.

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For milk, sugar, salt, cream.

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Casgrain & Charbonneau, Ltée., Montreal.
General Electric X-Ray Corporation, Ltd., Montreal.
Ferranti Electric Ltd., Mt. Dennis, Ont.
The Stevens Companies, Toronto.
X-Ray & Radium Industries, Limited, Toronto.

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Thomas A. Edison of Canada, Ltd., (Ediphone Div.), Toronto.

DISHWASHING COMPOUNDS
Cody Paper Products, Limited, Saint John, N.B.
Colgate-Palmolive-Peet Co., Ltd., Toronto.
Dustbane Products, Ltd., Ottawa.
Dye & Chemical Co. of Canada, Ltd., Kingston, Ont.
Thomas Gibson & Co., Ltd., Toronto.
Huntington Laboratories of Canada, Ltd., Toronto.
McKague Chemical Co., Ltd., Toronto.
Stanley Brock, Limited, Winnipeg.

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G. S. Blakeslee & Co., Ltd., Toronto.
General Steel Wares, Ltd., Toronto.
Hobart Mfg. Co., Ltd., Toronto.
S. H. Newman Co. Ltd., Toronto.
Robert Simpson Co. Ltd., Toronto.
Toledo Scale Co. of Canada, Limited, Windsor, Ont.
Wrought Iron Range Co., Ltd., Toronto.

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Cody Paper Products, Limited, Saint John, N.B.
Dustbane Products, Ltd., Ottawa.
Dye & Chemical Co. of Canada, Ltd., Kingston, Ont.
Thomas Gibson & Co., Ltd., Toronto.
H. S. Hunnisett Co., Toronto.
Huntington Laboratories of Canada, Ltd., Toronto.
Parke, Davis & Co., Ltd., Walkerville, Ont.
West Disinfecting Co., Ltd., Montreal.
G. H. Wood & Co., Limited, Toronto.

DISINFECTORS, METAL
American Sterilizer Co., Erie, Pa.
Canadian Laundry Machinery Co., Ltd., Toronto.

DISPENSERS
Liquid Soap
Dustbane Products, Ltd., Ottawa.
Thomas Gibson & Co., Ltd., Toronto.
H. S. Hunnisett Co., Toronto.
Huntington Laboratories of Canada, Ltd., Toronto.
West Disinfecting Co., Ltd., Montreal.
G. H. Wood & Co., Ltd., Toronto.

DOCTORS' PAGING SYSTEMS
Cannon Electric Co., Ltd., Toronto.
Edwards of Canada, Ltd., Montreal.
Electro-Vox, Inc., Montreal.

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Cannon Electric Co., Ltd., Toronto.
Edwards of Canada, Ltd., Montreal.

DOLLS, HOSPITAL
Clay-Adams Co., Inc., New York, N.Y.

DOORS, FLUSHWOOD
Canada Flushwood Door, Ltd., Terrebonne, Que.

DRAINAGE TUBING
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Sterling Rubber Co., Ltd., Guelph, Ont.
Viceroy Mfg. Co., Ltd., Toronto.

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Woolens wash

SOFTER, FLUFFIER

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Low Titre . . . Pure Powdered Soap

The true secret of washing satisfaction lies in soft, bright, natural looking woolens . . . crisp, clear coloured fabrics . . . just what you can be sure of every time with Kwiksolv.

CUT GENERAL LAUNDRY WASHING COSTS WITH GOLDEN XXX

GOLDEN XXX, a blend of pure fat, neutral and uniform, with special wetting and penetrating power, washes more thoroughly at moderate temperature (150°) . . . rinses more easily and reduces washing wear. Saves money and fuel.

FREE ADVISORY SERVICE. *Let your Colgate representative advise you how best to use Colgate products in your laundry establishment; or write for free booklet on your business letterhead.* **Industrial Division** 1-2 **Palmolive, Toronto**

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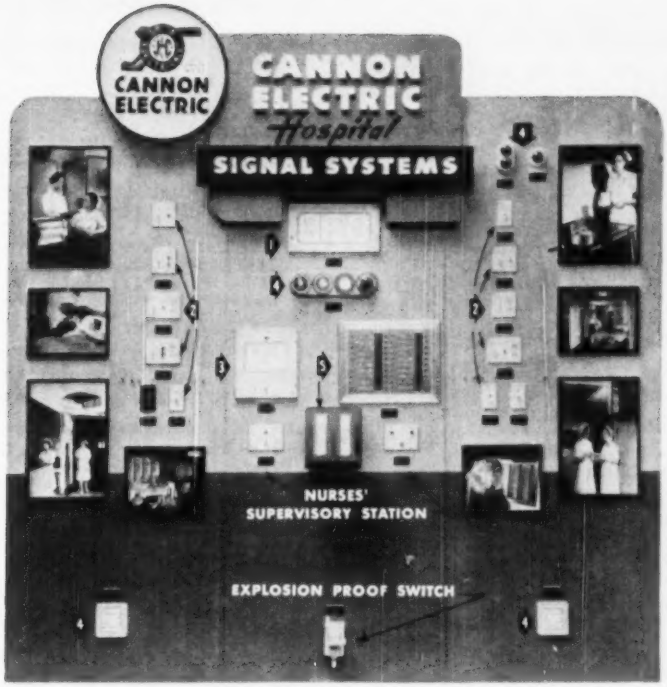

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Trouble Free — Non Automatic

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Switches are concealed and protected from the heat. Each element and switch can be removed and replaced independently of the others—quickly.

MADE IN THREE SIZES

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Bread is toasted on both sides at once. On the 2 larger sizes either ½ of the toaster can be operated alone.

Shipment from stock. Improvements in manufacturing methods have enabled us to substantially reduce prices.

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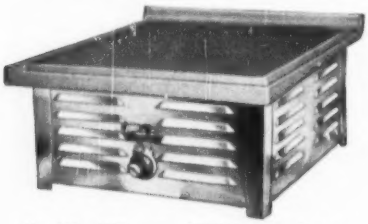
Automatic Heat Control—150° to 550° F.

For Continuous Duty Commercial Purposes



No. 153—4000 watts—220/230 volts—2 wire

Machined heavy grey iron cooking surface 18" x 18" with grease gutters and hole for connection to waste pipe. Finish—

Grease gutters & edges of casting: hi-heat alumina.
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Shipping weight — 110 lbs.
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Made by

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PEMBROKE ONTARIO

Manufacturers and Exporters

THE BUYERS' DIRECTORY

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All published studies agree that talc as a glove lubricant is unsafe. Animal experiments have shown the dangerous complications that follow talc implantation.

* * *

EFFECTS IN TISSUE

Talc consists chiefly of magnesium silicate. It causes granulomatous reactions in tissue, resulting in intra-abdominal adhesions, persistent sinus formation, or nodules in the wound.

* * *

"Implantation of glove powder may occur from unwashed gloves, perforations in gloves, spill on to sponges, instruments, and suture material, and by the air-borne route."[1]

* * *

SERIOUS COMPLICATIONS

"The frequency of such contamination is attested by the increasing number of case reports of serious complications due to talc. Animal experiments show that the granulomatous reaction can be regularly produced in the peritoneum, pleura, pericardium, muscle, joint, nerve and tendon."[1]

FOREIGN BODY REACTION

German[2,3] found intra-abdominal granulomata which he proved came from foreign body reaction to talc in 40 out of 50 unselected patients subjected to a second laparotomy.

* * *

Seelig[4,5] repeatedly demonstrated the danger of talc in mice, which are notably resistant to the production of adhesions, by injecting 2cc. of a 5% saline suspension of the powder intraperitoneally, and has stated that "the average surgeon cannot possibly perform this experiment and ever afterward face talcum powder with equanimity."

* * *

REPLACEMENT

As a replacement for talc, a wholly safe and efficient dusting powder is now available. This new powder, called Bio-Sorb, is a mixture of amylose and amylopectin, derived from corn starch, with a small amount of magnesium oxide added. It is treated physically and chemically to assure good lubrication after sterilizing.

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COMPATIBLE WITH TISSUE

Bio-Sorb is compatible with body tissues and is rapidly absorbed. It does not injure rubber gloves. It fits regular O.R. technics. Costs less than 2 cents per operation. Bio-Sorb has been used over two years in several hundred hospitals. Complete literature mailed on request.

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SAFETY CONFIRMED

The findings of Lee and Lehman[6] *that Bio-Sorb is safe have been confirmed by Lindenmuth*[7] *and MacQuiddy.*[8] *Postlethwait et al*[1] *concluded that "talc is a dangerous agent in its present use as a surgical glove lubricant," and stated that "a modified starch powder (Bio-Sorb) which is absorbed with little or no reaction is again suggested as a satisfactory substitute for talc."*

* * *

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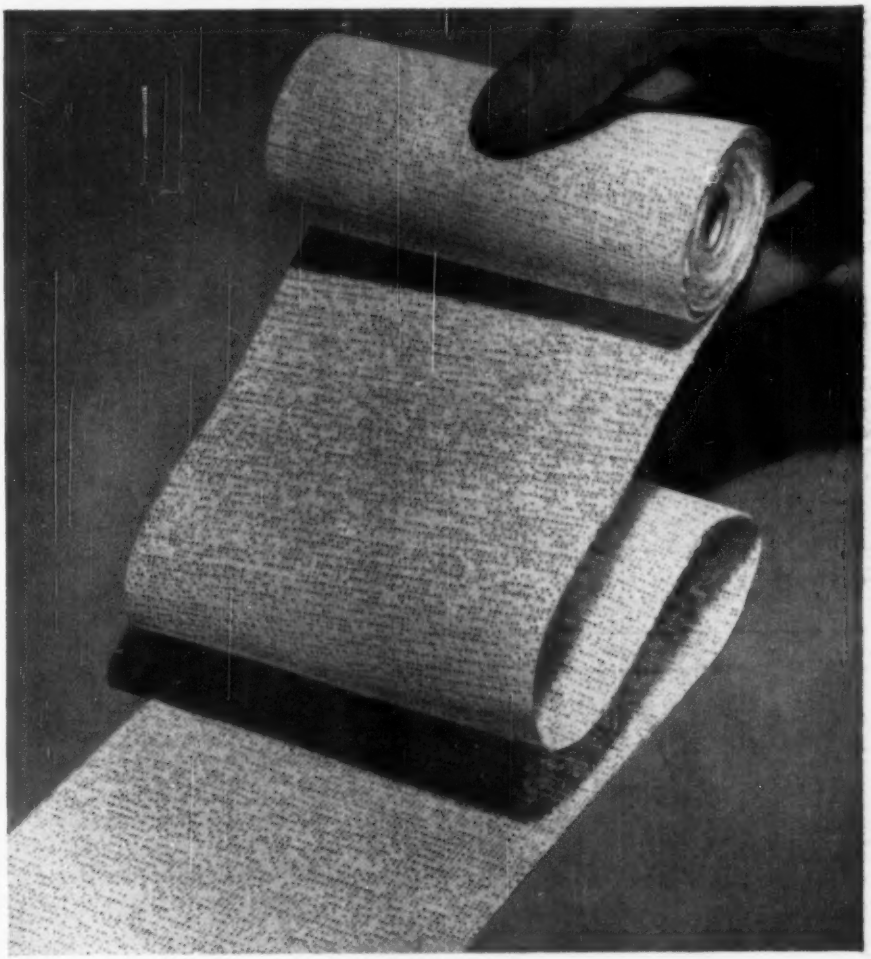

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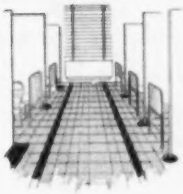

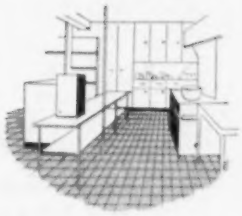

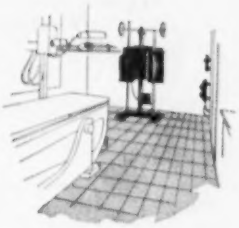

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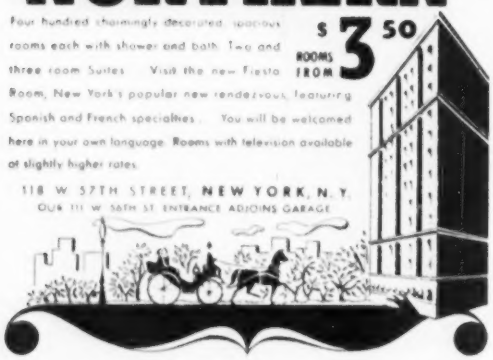

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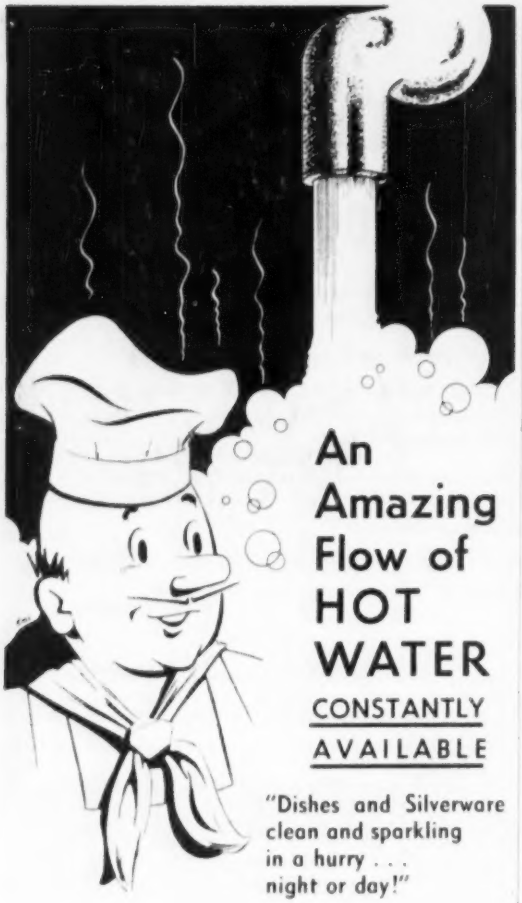

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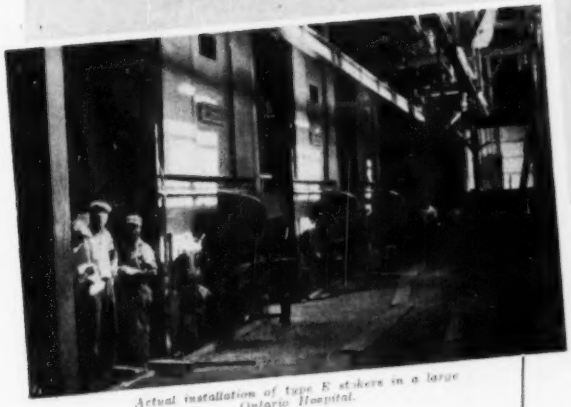

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St. Lawrence Sanitorium, Cornwall, Ont.
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Weston Sanitorium, Weston, Ont.
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Freeport Sanitorium, Kitchener, Ont.
Waterloo County House of Refuge, Kitchener, Ont.
Muskoka Hospital for Consumptives, Gravenhurst, Ont.
Toronto Hospital for Consumptives, Weston, Ont.
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Laurentian Sanitorium, Ste. Agathe, Que.
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Your floors, like the human heart, are vulnerable to the effects of neglect or indifferent treatment. To avoid shortening their "life-span" and increasing your sanitation overhead, wisely choose West floor products. Special care and treatment with West floor maintenance materials *prolongs the life* and beauty of your floors at an absolute minimum cost.

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5. KWYKWAX *Waxes and Finishes* all types of floors, except Terrazzo.	No rubbing or polishing necessary. Dries in 20 minutes (or less) with a high hard lustre, which resists traffic wear, protecting floor surface.

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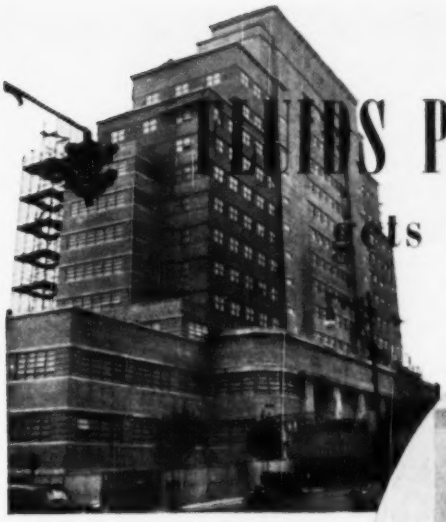

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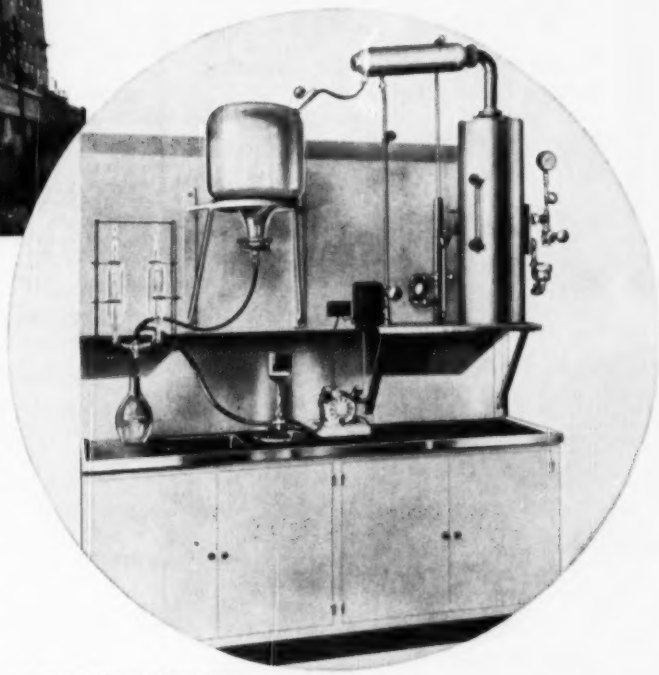
gets the *Green Light*



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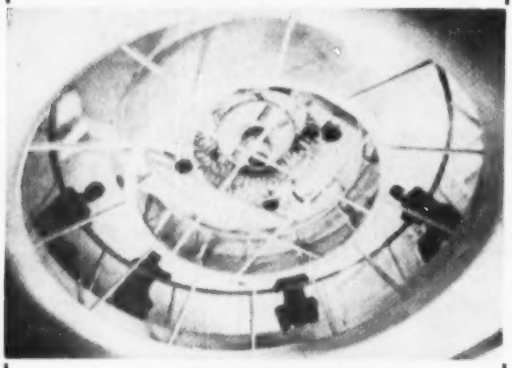
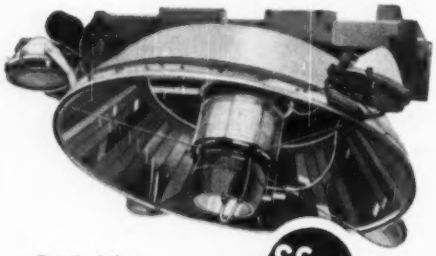


View from inside the operating theatre.



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Probably more linens get prematurely old and gray through improper washing than from any other cause. But, fortunately, there's an easy, inexpensive way to guard against this danger.

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BY WASHING THEM WITH OZONITE

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Count on Ozonite for excellent dirt removal and whiteness maintenance. Count on it for uniformly excellent results, too, because Ozonite itself is a uniform product.

Linens L-A-S-T
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Low Initial Cost — Low Operating Cost

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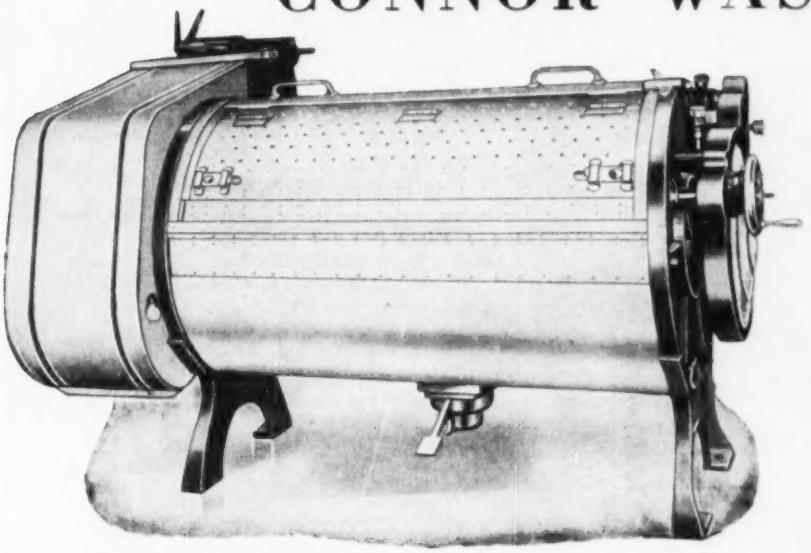

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No. 4 Ottawa Washer, complete with ¾ h.p. electric motor, single or three phase, 110-220 volt. Cylinder of hard brass, nickel plated and polished, 28" x 48". Capacity 40 sheets or 60 pounds dry clothes. Cylinder revolves on large, double race ball bearings, reducing power consumption 50 per cent. Weight 1,500 pounds.

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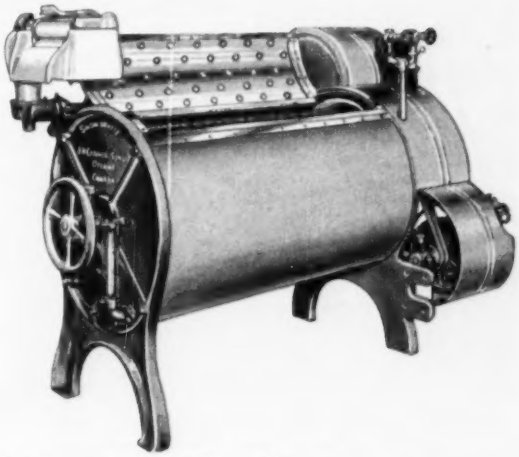

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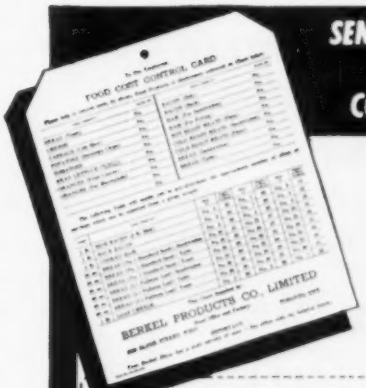

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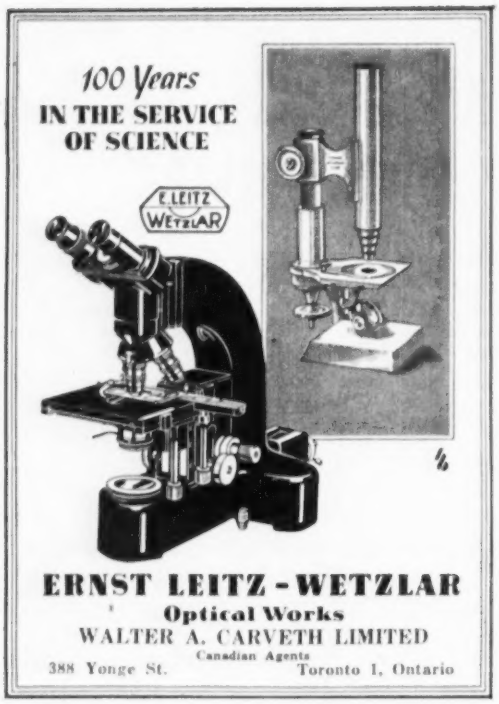

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MONEL

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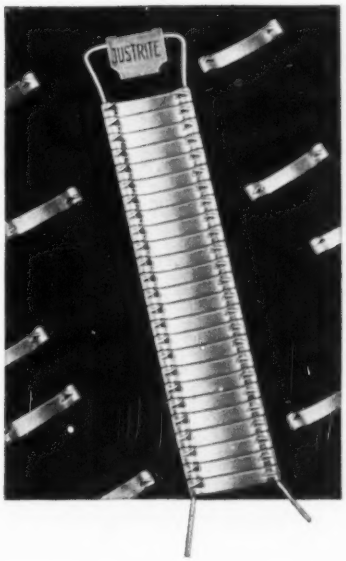

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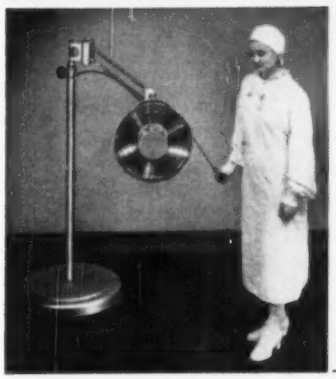

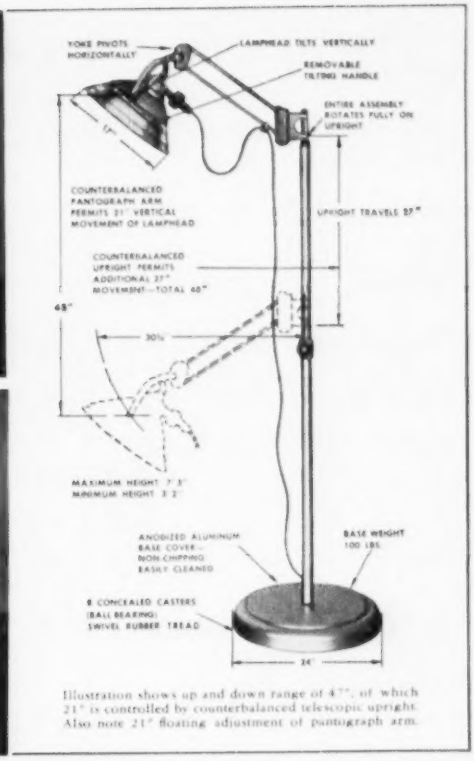

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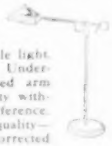

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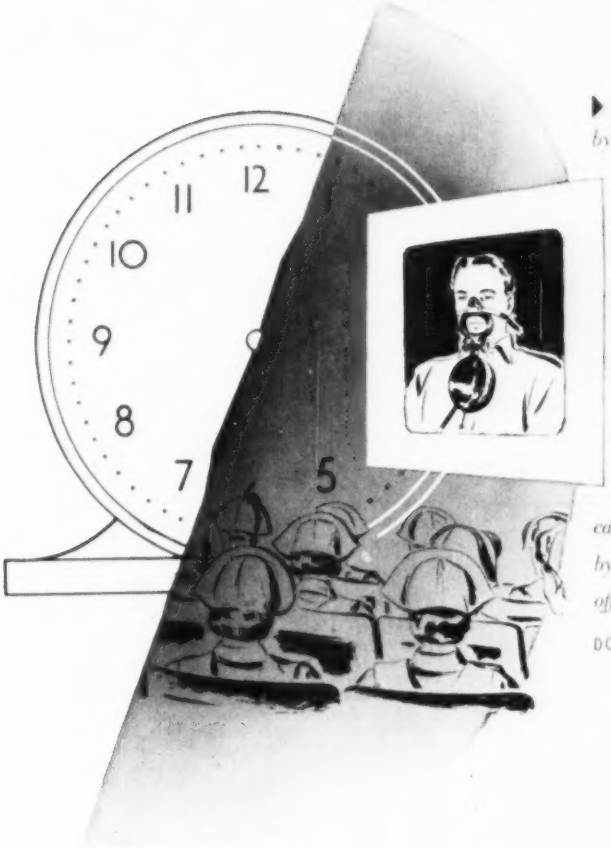

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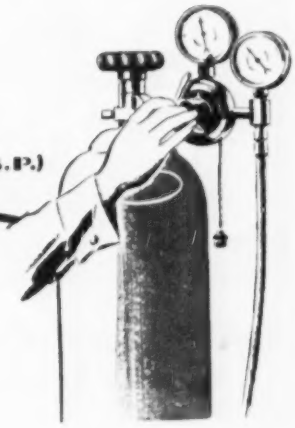

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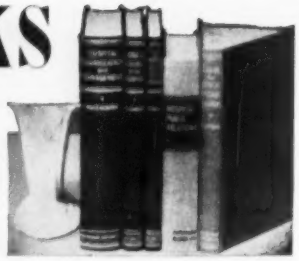

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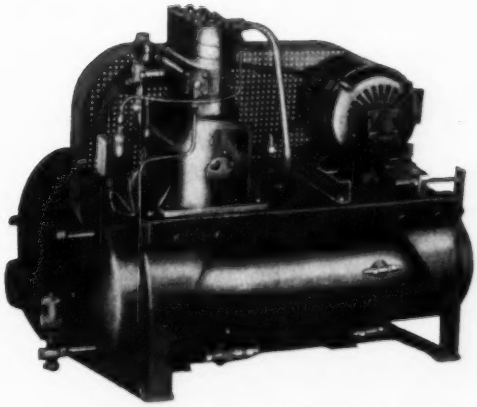

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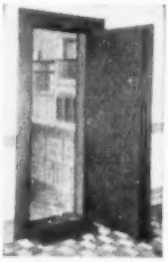

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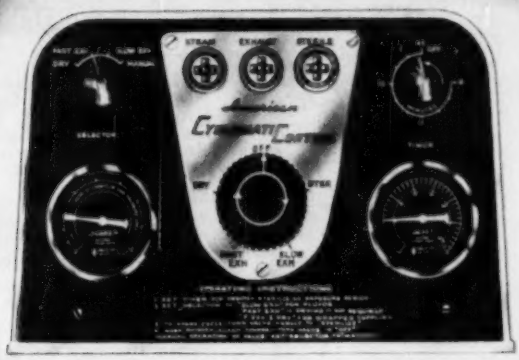

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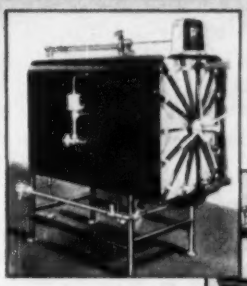

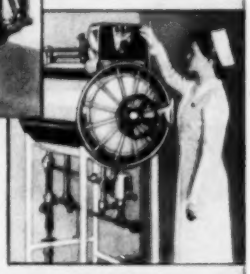

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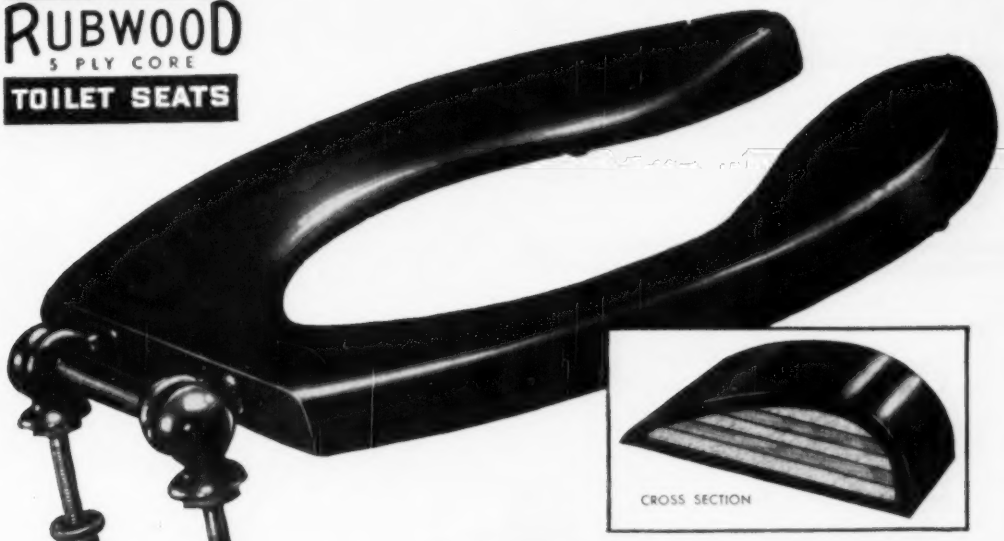

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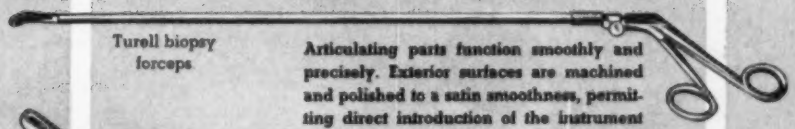

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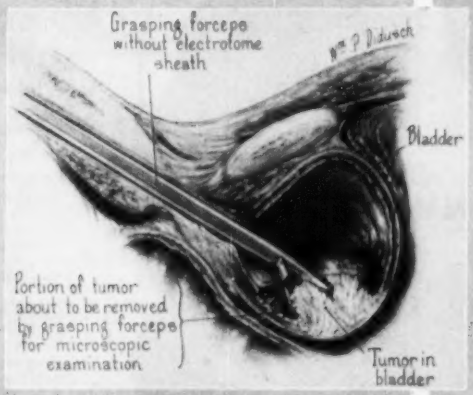

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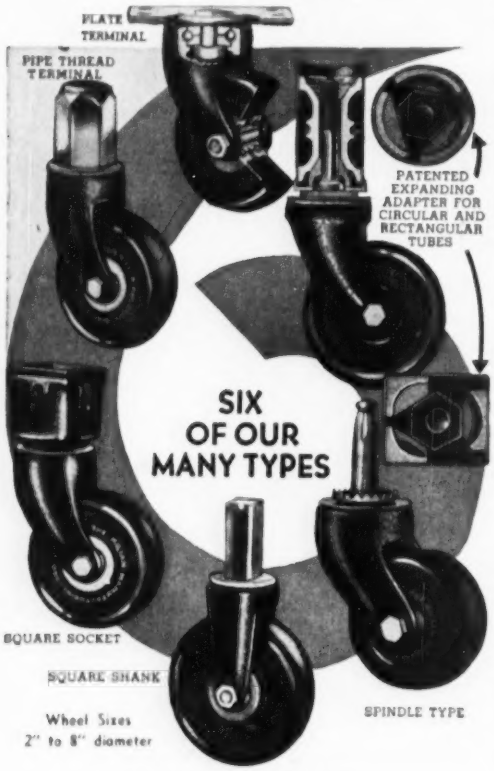

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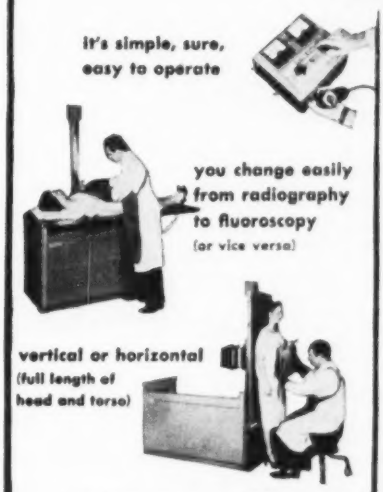

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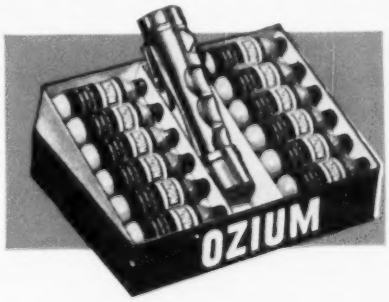

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